

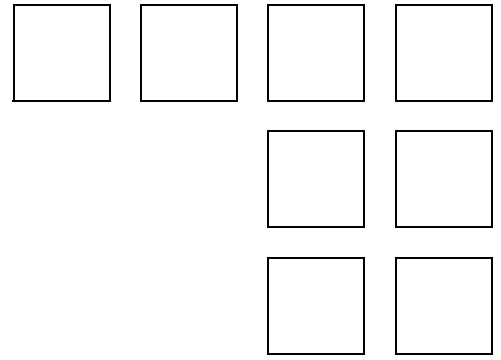


SHAPING POLICY

for Maternal and
Newborn Health

A Compendium of Case Studies





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United States Agency for International Development
Bill & Melinda Gates Foundation



JHPIEGO is a nonprofit international health organization dedicated to improving the health of women and families. Established in 1973, JHPIEGO—an affiliate of Johns Hopkins University headquartered in Baltimore, Maryland—works in more than 30 countries through its collaborative partnerships with public and private organizations, and local communities. www.jhpiego.org

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FOREWORD

Close to four million newborns died in the year 2000—nearly 40 percent of all childhood deaths. In the same year more than half a million women died during pregnancy or childbirth, or from complications shortly afterwards. For every woman who dies, 30 to 50 women suffer injury, infection, or disease. This human tragedy is intolerable when we have the evidence and knowledge to do something about it.

More than a decade of research has shown that relatively simple and affordable measures can significantly reduce the health risks to mothers and babies. For example, most maternal deaths could be prevented if women had access to appropriate healthcare during pregnancy, childbirth, and the postpartum period. And a significant number of stillbirths and newborn deaths could be prevented if women received good quality care during pregnancy and delivery.

There are many examples where quite straightforward interventions can save lives. Infant siblings born less than 2 years apart are significantly more likely to die. Many women start pregnancy with nutritional deficiencies. These deficiencies often get worse during pregnancy, increasing the risk of nutritional deficiencies in the newborn. Maternal infections also pose significant risks to the mother's own health and that of her child.

Malaria is associated with spontaneous abortion and stillbirth—women who develop severe anemia due to malaria are at increased risk of death. HIV infection not only affects maternal survival, it can also be transmitted to the newborn during pregnancy or delivery and in the postpartum period. Tetanus affects both mothers and newborns. Approximately one-third of the newborn deaths result from asphyxia, due to poor management during and immediately after delivery.

We know action in these areas will benefit both mothers and their infants.

Alongside our growing body of knowledge there has also emerged a strong political commitment. In the 1990s, a series of global conferences organized by the United Nations identified maternal mortality and morbidity as an urgent public health priority, and mobilized international commitment to address the problem. Governments from around the world pledged to ensure access to a range of high-quality, affordable reproductive health services, including safe motherhood and family planning, particularly to vulnerable and underserved populations.

We have the knowledge. We have the commitment. The most important challenge that now faces everyone working in maternal and newborn health is how to make best use of them. One essential task will be to develop sound, workable policies based on practical experience. *Shaping Policy for Maternal and Newborn Health: A Compendium of Case Studies* is a great starting point for this process. It is full of examples of how to transform knowledge and good intentions into practical action and put an end to the death and suffering of millions of mothers and their infants.

Dr. Tomris Türmen

*Representative of the Director-General
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Case studies submitted by Save the Children—“The Proper Practice of Breastfeeding: Policy and Public Health in Bangladesh,” “Mobilizing Demand for Maternal and Neonatal Tetanus Immunization: Reaching Women in Pakistan,” “Nepal’s Neonatal Health Strategy: A Policy Framework for Program Development,” and “Advancing the Agenda of Newborn Health Policy and Programs in India: The Role of a Professional Association”—were supported through a grant to the Saving Newborn Lives initiative from the Bill & Melinda Gates Foundation.

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LIST OF ABBREVIATIONS

AMDD	Averting Maternal Death and Disability program
ANC	antenatal care
BBF	Bangladesh Breastfeeding Foundation
BMS	breast milk substitute
CDC	Centers for Disease Control and Prevention
CPPBF	Campaign for the Protection and Promotion of Breastfeeding
CSSM	Child Survival and Safe Motherhood program
DEED	discussion, education, evidence, and decision making
DFID	Department for International Development (UK)
DHMT	district health management team
ENC	essential newborn care
FCI	Family Care International
FHA	Family Health and AIDS program
ICPD	International Conference on Population and Development
IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Newborn and Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IPT	intermittent preventive treatment
JICA	Japan International Cooperation Agency
LAC	Latin America and the Caribbean
LHW	lady health worker
MCPC	<i>Managing Complications in Pregnancy and Childbirth</i>
MDG	Millennium Development Goal
MNH	Maternal and Neonatal Health Program
MNT	maternal and neonatal tetanus
MOH	Ministry of Health
NGO	nongovernmental organization
NMCC	national malaria control committee
NNF	National Neonatology Forum
NNHS	National Neonatal Health Strategy (Nepal)
NSMC	National Safe Motherhood Committee (Mexico)
PAC	postabortion care
PAHO	Pan American Health Organization
PNPs	policies, norms, and protocols
PQI	performance and quality improvement
RCH	Reproductive and Child Health program
SEARCH	Society for Education, Action and Research in Community Health
SIAS	Sistema Integrado de Atención en Salud (Integrated System for Health Care)
SNL	Saving Newborn Lives initiative
SP	sulfadoxine-pyrimethamine
TT	tetanus toxoid
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

Since its inception in 1987, the Safe Motherhood Initiative has raised awareness of maternal health issues and has provided a platform for action at the global and national levels, under the stewardship of the Safe Motherhood Inter-Agency Group. Maternal mortality reduction is now accepted globally as a public health imperative, as is evidenced by its inclusion in the Millennium Development Goals (MDGs) adopted by world leaders at the United Nations Millennium Summit in September 2000. Concern has also been growing about the millions of stillbirths and newborn deaths that occur each year. Reducing child mortality is another of the MDGs, but experts argue that the target for reduction will only be met if newborn deaths can be cut by at least half. The Saving Newborn Lives initiative and an interagency group, the Healthy Newborn Partnership, were both established in 2000 to promote attention and action to improve newborn health. Achieving both the maternal and child health MDGs will require greater emphasis on proven, cost-effective measures.

In recognition of the strong links between maternal and newborn health, the Partnership for Safe Motherhood and Newborn Health will be launched in late 2003. This expanded global mechanism will be a forum for exchange and collaboration between multilateral agencies, nongovernmental organizations, donors, and others working to address both maternal health and newborn health issues within the MDG framework. The partnership will involve a larger range of organizations in the global dialogue for maternal and newborn health. It will also highlight the links between poverty and maternal and newborn health, and emphasize the need to address issues of equity within and between countries in terms of access to services for mothers and newborns.

Government commitment to improved maternal and newborn healthcare has grown across countries and regions. Key stakeholders, including government policymakers and leaders, international and local nongovernmental organizations, professional associations, and international donor agencies, have strengthened and expanded the safe motherhood movement, and are beginning to add to the newborn health component, through creative programming strategies. Reproductive health policies that support accessible and appropriate safe motherhood services are evidence of a government's commitment to women's health and related newborn health. More important, however, is the realization of these policies through program implementation.

The case studies in this compendium were developed by the Maternal and Neonatal Health Program, Saving Newborn Lives/Save the Children, and Family Care International to demonstrate different approaches to influencing national policy in maternal and newborn health. As nongovernmental organizations, we are particularly interested in how civil society and nongovernmental organizations can contribute to positive change. The case studies emphasize the processes involved in securing national policy commitments and the specific changes they are making in maternal and newborn health and healthcare. Each case study presents a strategy for achieving or influencing policy change, details of the implementation process, and a discussion of results.

To set the stage, we begin with an overview of evidence on the impact of maternal and newborn health interventions in less-developed countries and the role of research in developing sound policies and programs for mothers and newborns. The case studies follow and are grouped by theme in four sections.

Global Initiatives: Inspiring National Implementation highlights country experiences in both actualizing policy change and informing policy development. This section provides three examples of international initiatives and global alliances that have influenced maternal and newborn health policies and programs at the country level. The global breastfeeding movement provided support for health professionals in Bangladesh to launch the national Campaign for the Protection and Promotion of Breastfeeding. The Global Maternal and Neonatal Tetanus Elimination Program provided the impetus for Pakistan's national efforts. The Pakistan case study also emphasizes the crucial contribution of demand generation strategies in effective program implementation. The use of the World Health Organization's *Managing Complications in Pregnancy and Childbirth* to shape national policy development is the focus of the final case study in this section. The piece illustrates how international guidelines have influenced policy development in Guatemala, Indonesia, Zambia, and other countries.

Building Commitment: Action for Policy Change demonstrates how national commitment for maternal and newborn care can be translated into action through stakeholder participation, targeted advocacy, and local ownership. The first two case studies profile the use of advocacy strategies for increased resource commitment at the local level as highlighted in the Kuningan district of Indonesia and the development of Nepal's Neonatal Health Strategy with support from Saving Newborn Lives. The third case study describes how a forum of leading pediatricians in India mobilized government support for advancing newborn health nationally. The final case study highlights the revision of Burkina Faso's national Reproductive Health Policies, Norms and Protocols and their use at the district level to inform clinical training and performance and quality improvement for essential maternal and newborn care.

The third section, ***Program Learning: Informing Policy Design***, demonstrates how programming can influence national-level policy. The first case study in this section describes how the development and implementation of a life-saving skills training strategy supported by Family Care International in Kenya is leading to the enactment of a Ministry of Health policy authorizing "mid-level personnel to provide high-level care to manage obstetric complications." The second country example comes from Guatemala, where the Maternal and Neonatal Health Program worked with the Ministry of Health to institutionalize *CaliRed*—a performance and quality improvement process—as Guatemala's national strategy for improving the quality of maternal and newborn healthcare. The final paper in the section provides an overview of how research data can be used to inform policy dialogue and change. Although the paper focuses exclusively on policy change in Africa for the management of malaria during pregnancy, it is an example of how research results can be used to inform policy dialogue across maternal and newborn health.

The Power of Partnerships: Moving the Agenda Forward highlights the centrality of partnerships to the safe motherhood movement. An example of “how common ground can be used to forge nontraditional but effective partnerships” is outlined in the case study about Mexico’s National Safe Motherhood Committee. The final case study in the compendium documents the work of the Regional Task Force on Maternal Mortality Reduction and its effort to develop a regional consensus on safe motherhood priorities in Latin America and the Caribbean.

We hope that *Shaping Policy for Maternal and Newborn Health* will offer insights into policy processes at many different levels. The case studies included here demonstrate the contribution of individuals as powerful agents for change; the importance of partnerships at all levels; and how both national and international organizations can work with governments to achieve changes that will have a lasting effect on people’s lives.

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RESEARCH OVERVIEW

Basing Newborn and Maternal Health Policies on Evidence

Zulfiqar A. Bhutta, Gary L. Darmstadt, Elizabeth I. Ransom, Ann M. Starrs, and Anne Tinker

Although health indicators overall have improved in most of the world over the past 15 years, two critical indicators—maternal mortality and newborn mortality—have hardly changed.¹ In some countries, these death rates have even increased. World leaders at the United Nations Millennium Summit in September 2000 agreed on two critical goals for the year 2015: to reduce the maternal mortality ratio² by three-fourths, and to reduce deaths of children less than 5 years old by two-thirds. According to child health experts, the child health goal is unattainable without reducing newborn deaths by at least half, as these deaths now comprise 40 percent of all child deaths. Achieving these two goals will require greater emphasis on proven, cost-effective measures to save the lives of women and their newborns.

This paper presents findings from reviews of evidence on the impact of maternal and newborn health interventions in less-developed countries, and offers compelling support for using research as a tool for identifying the most effective measures for saving maternal and newborn lives. Several reviews of best practices to improve maternal health outcomes have been conducted in past years, particularly since the Safe Motherhood Initiative was launched in 1987. However, until recently, there was no such analysis of the impact of interventions on neonatal outcomes in developing countries. To fill this gap, the World Health Organization (WHO) and Save the Children's Saving Newborn Lives (SNL) initiative supported a global review of the impact of community-based interventions during the antenatal, intrapartum, and postpartum periods on perinatal and neonatal health status outcomes. The results of this study became available in 2003 and provide a solid foundation for policies, programs, and research studies related to maternal and newborn health. This paper emphasizes the new findings, while recommending an integrated approach to safe motherhood and newborn health.

THE ROLE OF RESEARCH IN CRAFTING SOUND HEALTH POLICIES AND PROGRAMS

Carefully conducted and analyzed research can save lives by helping decision makers design effective policies and programs. For research to influence policy, however, it needs to be communicated effectively and used in the decision-making process.

Several international initiatives highlight the importance of using research to inform policy. The Better Births Initiative, for example, strives to use research to influence

Adapted from Bhutta ZA, GL Darmstadt, and EI Ransom. 2003. "Using Evidence to Save Newborn Lives." *Policy Perspectives on Newborn Health*, no. 3. Population Reference Bureau and Saving Newborn Lives: Washington, DC. Copyright © Population Reference Bureau. Adapted with permission. A more comprehensive technical paper by Bhutta, ZA, GL Darmstadt, and B Hasan, "Community Based Interventions for Improving Perinatal and Neonatal Outcomes in Developing Countries: Review of the Evidence," is forthcoming.

policy decisions about maternal healthcare. The initiative, which was developed when researchers observed a discrepancy between research evidence and actual practice in labor wards in several countries, “aims to ensure that clinical policies and practices...are grounded in reliable research.”³ The Cochrane Collaboration, an international organization that seeks to help people make well-informed healthcare decisions by “preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions,” provides an Internet database of these reviews.⁴

WHO has launched a broad initiative on health research systems analysis that will assess how health research is used. WHO provides an online resource on up-to-date research findings about reproductive healthcare in less-developed countries, and plans to focus on how research advances can lead to improved health in its *World Health Report 2004*.

Bilateral donors are also investing in systems and projects to support wide dissemination of population and health data, research results, and best practices. The U.K. Department for International Development (DFID) funds “id21,” an electronic network that disseminates summaries of new research. The U.S. Agency for International Development (USAID) supports several organizations, including the Center for Communication Programs at Johns Hopkins University, which disseminates information about effective healthcare and other practices, and the Population Reference Bureau, which helps policy-level audiences access and use technical information and survey results.

WHAT RESEARCH SAYS ABOUT HOW TO SAVE THE LIVES OF MOTHERS AND NEWBORNS

Improving maternal and newborn health requires incorporating the needs of these vulnerable populations into existing health programs. For example, many newborn lives can be saved in primary care settings if health professionals recognize and treat serious infections. These efforts may be especially important—even potentially life saving—in circumstances where referral may not be possible. Managing life-threatening maternal complications often requires facility-based care, and therefore requires that the health system function at some minimal level, with skilled personnel, supplies and equipment, and a communication and transport system for referral. To improve both maternal and newborn health, therefore, the health sector needs to work effectively from the community to the hospital level, making maternal and neonatal health indicators a good measure of the effectiveness of health sector reform.

Factors other than the effectiveness of the health system come into play as well; research shows that increasing a woman’s education and social status improves the health of other household members, including newborn babies. When women are able to space their pregnancies and regulate family size, they and their children are more likely to survive and live healthy lives. In addition, designing health interventions with a greater focus on equity will improve maternal and newborn health. A recent analysis of Demographic and Health Survey data shows that the

poorest population groups have significantly higher newborn death rates than the richest groups, and lower rates of antenatal care and skilled attendance at birth.

The health of a newborn is inextricably linked to the health of the mother; the majority of newborn deaths are caused by the poor health of the mother during pregnancy, or by the poor care she and her newborn receive during and immediately after childbirth. Safe motherhood programs are thought to provide a cost-effective way to improve newborn and maternal health; conversely, programs designed to improve newborn health and survival may also benefit mothers. In particular, the availability of skilled care during childbirth is considered critical to maternal and newborn health and survival. Skilled care refers to the process by which pregnant women and their infants receive adequate care, especially during and immediately after childbirth; it includes, but is not limited to, care for women with life-threatening complications.

RESULTS OF THE 2003 INTERVENTION REVIEW

The most recent WHO/SNL review assessed interventions to prevent stillbirths and improve newborn health and survival during the period before birth (antenatal), during childbirth (intrapartum), and after childbirth (postnatal). Because most newborns who die do so at home during the first week of life, without any contact with a healthcare provider, the WHO/SNL review focused on programs in communities with limited access to hospitals or other healthcare facilities. The review also assessed public health programs and interventions already in place, recommendations from WHO and other expert institutions and individuals, biological plausibility, and evidence from studies of developed countries. The review did not include evaluation of interventions that are currently being assessed, such as certain obstetric interventions and HIV/AIDS prevention and treatment.

Table 1 summarizes the principal elements of successful interventions for saving the lives of newborns that emerged from the findings of the WHO/SNL review, as well as available analyses of safe motherhood interventions.

Table 1. Evidence-Based Essential Maternal and Newborn Care

ANTENATAL CARE	CHILDBIRTH CARE	POSTPARTUM/ NEWBORN CARE
<ul style="list-style-type: none"> • Provide tetanus toxoid immunization • Promote proper nutrition, including iron, folate, and iodine supplements and balanced protein and energy consumption • Detect and treat maternal infections (syphilis and malaria) • Provide breastfeeding counseling • Check blood pressure for early detection of pre-eclampsia/eclampsia 	<ul style="list-style-type: none"> • Use partograph during labor for early detection of obstructed labor • Administer antibiotics in the event of prolonged rupture of membranes • Ensure clean delivery • Actively manage third stage of labor • Resuscitate asphyxiated babies 	<ul style="list-style-type: none"> • Prevent and treat newborn hypothermia by drying and warming • Prevent and treat newborn hypoglycemia • Encourage immediate, exclusive breastfeeding and maternal nutrition • Provide newborn eye care • Prevent and treat infections • Encourage birth spacing
Ensure transport and access to appropriate referral care for life-threatening obstetric and neonatal complications		

Provide Essential Care to Mothers during Pregnancy

The antenatal care a woman receives can have a strong influence on her newborn's health and potential for survival. Traditionally, antenatal care required pregnant women to make multiple visits to healthcare providers and receive a wide variety of services. However, in recent years, research has shown that a narrower range of services during fewer visits can also improve maternal and newborn health. These services include immunizing mothers against tetanus, giving supplemental iron and folic acid to women of childbearing age, promoting the intake of adequate amounts of iodine, promoting consumption of balanced amounts of energy and protein, monitoring blood pressure for detection of hypertension, educating women about the importance of immediate and exclusive breastfeeding, providing antimalarial drugs and using insecticide-treated bed nets in areas where malaria is endemic, and providing screening and treatment in areas where syphilis is endemic.

Provide Care during Childbirth

Several interventions during labor and childbirth are key to preventing or managing complications. These include using the partograph to detect prolonged/obstructed labor, reducing the risk of infection to mothers and newborns by keeping the birth attendant's hands and all contact with the newborn's umbilical cord (especially cutting instruments and ties) clean, using active management of the third stage of labor⁵ to reduce the risk of postpartum hemorrhage, and resuscitating newborns who are not breathing normally after birth. Reviews of safe motherhood interventions have emphasized the critical importance of skilled care during childbirth in preventing maternal mortality, which includes attendants trained in midwifery skills

and prompt management or referral of obstetric complications, such as postpartum hemorrhage.

Provide Postnatal Care

Mothers and newborns are especially vulnerable during the period immediately following delivery. Over 60 percent of maternal deaths occur during the first 6 weeks after birth, and nearly half of those deaths take place during the first day after delivery. Two-thirds of neonatal deaths occur in the first week of life, and two-thirds of those deaths occur in the first 24 hours. Certain actions can make this period safer for newborns, including preventing and managing hypothermia, encouraging mothers to breastfeed, and preventing and managing infections.

CONCLUSION

Recent research on maternal and newborn health has demonstrated that many interventions to protect a mother's health also benefit the newborn, and vice versa. Given the relative neglect that mothers and newborns have suffered, their centrality to the Millennium Development Goals, and the cost-effectiveness of maternal and newborn health interventions, a greater emphasis on safe motherhood and newborn health is clearly needed within many health sectors.

Using Evidence to Design a Home-Based Approach to Newborn Healthcare in Gadchiroli, India

In India's Gadchiroli district, the Society for Education, Action and Research in Community Health (SEARCH) used evidence about effective newborn care to develop a home-based approach to benefit newborns and their mothers. More than 80 percent of births in rural India occur at home and far from health facilities. After two years of study, SEARCH introduced maternal and neonatal care through trained village health workers and trained birth attendants. Village health workers provide care during pregnancy and through the infant's first month of life. They are trained to resuscitate asphyxiated babies, support breastfeeding, prevent and treat hypothermia, and recognize and treat infections. They are also given basic supplies such as clean delivery kits, iron/folate tablets, and condoms.

By the third year of this intervention, there was a remarkable 62 percent decline in neonatal mortality, which was also accompanied by significant declines in neonatal and maternal morbidities. In addition, a followup study by SEARCH found that there was no replacement spike in mortality of infants who survived the neonatal period due to home-based neonatal care. The findings of the Gadchiroli trial are important, given the challenge of providing care for remote populations. Such community-based approaches are being evaluated in various settings in Africa and South Asia, with additional elements of improved care-seeking practices and referral systems.

NOTES AND REFERENCES

- 1 Maternal mortality is the death of a woman from the complications of pregnancy or childbirth; neonatal mortality is the death of an infant less than 1 month old.
- 2 The maternal mortality ratio is the number of maternal deaths per 100,000 live births.
- 3 Global Health Council. 2003. *Making Childbirth Safer through Promoting Evidence-Based Care*. Global Health Council: Washington, DC. Retrieved 1 September 2003, from <http://www.globalhealth.org/assets/publications/MakingChildbirthSafer.pdf>

- 4 Cochrane Collaboration. 2002. *The Ten Principles of the Cochrane Collaboration*. Retrieved 1 September 2003, from <http://www.cochrane.org/cochrane/cc-broch.htm>.
- 5 Active management of the third stage of labor includes administration of a prophylactic oxytocic to the mother with or immediately after the birth, early cord clamping and cutting, and controlled cord traction.

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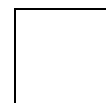
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GLOBAL INITIATIVES:

Inspiring National
Implementation

SHAPING
POLICY
for Maternal and
Newborn Health

CASE STUDY #1

THE PROPER PRACTICE OF BREASTFEEDING: POLICY AND PUBLIC HEALTH IN BANGLADESH

By M Q-K Talukder

From colonial times, Bangladesh inherited from the British a hospital-based health system in which doctors focused on curing disease. Improving public health was not perceived as a need for the population, and the government seldom provided public health services. An unstable political system, widespread poverty, and lack of commitment from the medical community left people to suffer in all spheres of life. Today, the health and nutritional status of Bangladesh's women and children is among the worst in the world.

The introduction of powdered formula for infants following World War II greatly eroded the practice of breastfeeding in Bangladesh, with ill effects for both mothers and babies. In Bangladesh, as in other developing countries, bottle-feeding resulted in diarrhea, infections, and malnutrition, with high morbidity and mortality as a result of diluted and contaminated artificial feeding. By the early 1980s, the high prevalence of bottle-feeding in Bangladesh extended even to the villages. Healthcare providers often prescribed breast milk substitutes (BMSs). The bottle-feeding culture and practices in maternity centers were so pervasive that almost all maternity beds provided a feeding bottle for the newborn in their side lockers. Unethical marketing of BMS was widespread.

In Bangladesh, immediate breastfeeding was not traditionally practiced, and exclusive breastfeeding was virtually nonexistent. Mothers tended to discard colostrum (first milk), substituting prelacteal feeds such as sugar water, honey, or oil instead of breast milk as the first feed for all newborn babies. Initiation of breastfeeding by most mothers took place on the third or fourth day. In the event of illness, mothers would cease breastfeeding. Complementary feeding practices were also unsatisfactory, consisting of bulky, energy-thin feeds, with weaning occurring either too early or too late.

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Such was the state of affairs in Bangladesh in 1979, when the World Health Organization (WHO) and UNICEF held a meeting in Geneva for the first time to emphasize the importance of breastfeeding—the first in a series of important initiatives to address this issue and other child health and nutrition concerns. Before



Photo: Dr. Syed Moshfiqur Rahman

As a result of the breastfeeding movement and the government's policy commitments, breastfeeding prevalence in Bangladesh has risen significantly in recent years. According to the Bangladesh Breastfeeding Survey, initiation of breastfeeding within the first 24 hours after birth is nearly universal.

1980, there was hardly any discussion within the medical profession in Bangladesh of the importance of breastfeeding, let alone of a public health intervention to promote it. But the leadership of global agencies on this important issue had a significant impact on breastfeeding policy and practice in Bangladesh.

This case study describes the origins of the breastfeeding movement in Bangladesh, the government of Bangladesh's support for the initiative, and the partnership that was established among the health professions, United Nations (UN) agencies, bilateral agencies, and the World Bank to change breastfeeding practices. The introduction of breastfeeding contributed to better health and nutritional status among the nation's children within a decade.

INTERNATIONAL INITIATIVES TO PROMOTE BREASTFEEDING

The meeting on Infant and Young Child Feeding, which WHO and UNICEF sponsored in Geneva in October 1979, involved 150 representatives from governments, industry, the UN system, and nongovernmental

organizations (NGOs). The meeting resulted in broad recommendations on the encouragement of breastfeeding, education of health personnel, improvement of women's status, and development of complementary foods. The meeting participants called for severe restrictions on infant formula marketing.

In the same year, the International Baby Food Action Network was formed to persuade the baby food industry to change its marketing practices for infant formula, particularly in developing countries. In May 1981, the World Health Assembly overwhelmingly adopted the International Baby Milk Marketing Code, which put curbs on the advertisement of infant formula and other breast milk substitutes.

In 1989, WHO and UNICEF published "Protecting, Promoting and Supporting of Breastfeeding: The Special Role of Maternity Services," which laid out 10 steps to successful breastfeeding. A 1990 meeting of WHO and UNICEF policymakers in Florence, Italy, resulted in the Innocenti Declaration, which called upon all nations to adopt national breastfeeding policies, establish national breastfeeding coordinating agencies, take appropriate steps to institutionalize the BMS code, implement the 10 steps in maternity service facilities, and help the working mother to breastfeed properly. UN agencies and 32 countries endorsed this declaration.

The World Alliance for Breastfeeding Action was formed in 1991 as an umbrella network for all national organizations and individuals dedicated to the protection and promotion of breastfeeding. Subsequently, during the 1990s, commitments to protect and promote breastfeeding were made in various global initiatives, including the Convention of the Rights of Children, the World Summit for Children, the International Congress of Nutrition Declaration, the International Conference on Population and Development, and the Baby Friendly Hospital Initiative. In May 2001, the World Health Assembly adopted a resolution recommending exclusive breastfeeding for a period of 6 months. A year later, it reaffirmed its position on breastfeeding in its Global Strategy for Infant and Young Child Nutrition.

THE BEGINNING OF BANGLADESH'S BREASTFEEDING MOVEMENT

In the early 1980s, a national breastfeeding campaign was initiated by a group of child health professionals in Bangladesh who were concerned about the alarming erosion of breastfeeding practices and its effect on the nutritional and health status of children. By 1989, they had joined with UNICEF, representatives from the government of Bangladesh, and NGOs to form a group called the Campaign for the Protection and Promotion of Breastfeeding (CPPBF), which later became known as the Bangladesh Breastfeeding Foundation (BBF).

UNICEF supported CPPBF activities from 1989 to 1995 through the Institute of Public Health and Nutrition of the Ministry of Health and Family Welfare, which promoted the breastfeeding movement through a nationwide awareness campaign. Divisional workshops, held in four medical colleges, brought together medical professionals, social workers, NGOs working in health and allied fields, administrators, and politicians. A national conference on breastfeeding was held in 1991, and 800 participants from diverse disciplines attended. The Dhaka Declaration—a pledge for the protection, promotion, and support of breastfeeding—was the chief outcome of that conference, and was signed by the President and Prime Minister of Bangladesh, cabinet ministers, and the participants.

The first action to emerge from this new breastfeeding coalition was a proposal submitted by CPPBF to the government of Bangladesh to support breastfeeding activities within the primary healthcare system and in hospitals. Training programs on the importance of breastfeeding and how to help mothers to breastfeed properly were offered to health professionals in hospitals. The media were also used extensively for the promotion of breastfeeding. A series of advocacy meetings took place with Ministry

Among the goals and objectives outlined for the CPPBF were the following:

Goal:

To significantly lower morbidity and mortality of children and women in Bangladesh through successful breastfeeding

Objectives:

- To achieve and sustain exclusive breastfeeding for the first 5 months, ensuring colostrum for all
- To improve weaning practices and encourage continuation of breastfeeding for 2 years or more
- To improve the nutritional status of pregnant and lactating women

officials. Political commitments were obtained, and gradually breastfeeding promotion programs were integrated into ongoing programs.

The many activities, programs, and campaigns that have been supported in Bangladesh in the 20 years since the introduction of the breastfeeding movement are directly linked to the international policy agenda concerning proper nutrition and feeding of infants.

BANGLADESH'S COMMITMENT TO BREASTFEEDING POLICY

Since the end of Bangladesh's war of independence in the early 1970s, the country has struggled with the poor health and nutritional status of the population, and successive governments have been receptive to strategies for improving healthcare. In the mid-1980s, the government of Bangladesh adopted the Expanded Program on Immunization and the Control of Diarrheal Diseases program. Health professionals, particularly pediatricians, contacted government officials to advocate for the introduction of breastfeeding programs; and through regular workshops, the government and other important stakeholders were sensitized to the importance of breastfeeding. With the establishment of the CPPBF, the government of Bangladesh was persuaded to include breastfeeding as one of the interventions in its combined primary healthcare activities, which include both the diarrheal disease and immunization programs and programs addressing safe motherhood, family planning, treatment of minor illnesses, and others.

The government's growing commitment and the CPPBF's role in policy development can be seen in the introduction of the following initiatives:

- After the World Health Assembly passed the international code for the marketing of breast milk substitutes resolution in 1981, some of the founders of the CPPBF worked with the Ministry of Health and Family Welfare to introduce legislation regarding BMS, which the government passed in 1984. Subsequent amendments of the BMS marketing code ordinance were made by parliament in 1990.
- The Baby Friendly Hospital Initiative, which was launched worldwide by WHO and UNICEF in 1991, was also launched that year in Bangladesh by CPPBF and was endorsed as a national program within Ministry of Health and Family Welfare. The Baby Friendly Hospital Initiative is now an established and sustainable program in the country.
- World Breastfeeding Week, which is observed in more than 100 countries, has been a national program in Bangladesh since 1992.
- In 1994, the Director General of Health Services approved, disseminated, and began implementation of the hospital breastfeeding policy, which included the 10 steps of the Baby Friendly Hospital Initiative.

- In 1995, the Ministry of Health and Family Welfare introduced the Bangladesh Integrated Nutrition Project with financial assistance from the World Bank. The World Bank asked the BBF (as CPPBF became known 1995) to submit a proposal for breastfeeding activities within the integrated program, and the BBF's proposal was accepted in full. A full secretariat was established in 1995.
- In 2003, the government of Bangladesh and the World Bank asked the BBF to continue the breastfeeding protection and promotion programs within the National Nutrition Program (in essence, the continuation of the Bangladesh Integrated Nutrition Project). The Canadian International Development Association now funds this program.

ACHIEVEMENTS OF THE BREASTFEEDING MOVEMENT

Since the campaign for the protection and promotion of breastfeeding began, awareness of the importance of breastfeeding has been raised throughout Bangladesh. Increased awareness is also apparent at the policy level in the continuing efforts of the national government, health professionals, the UN, and bilateral agencies to continue crucial breastfeeding programs.

The Dhaka Declaration paved the way to implement the ordinance and amendments made in the parliament for the code for the marketing of BMS. The Director of the Institute of Public Health and Nutrition and the Civil Surgeons of the Districts are authorized to initiate legal action against milk companies that violate the code. The BBF finances their legal expenses. So far, three companies have been prosecuted and fined for violating the code. The BBF has trained 12,000 trainers, mostly within the healthcare system, in the management of breastfeeding. About 100 counselors have been trained in the management of breastfeeding, and 416 maternity service facilities out of a target of 550 have been transformed into Baby Friendly Hospitals.

Breastfeeding programs are incorporated within the primary healthcare system of the newly established Health and Population Sector Program. All healthcare providers received basic training to help mothers breastfeed properly. Fourteen research programs were conducted with financial help from the BBF, and the research results have been disseminated. The BBF also disseminates two quarterly bulletins on breastfeeding (one in Bangla and one in English) and materials such as posters and fliers.

IMPACT OF THE BREASTFEEDING POLICY

Since the BBF was formed in 1989, the breastfeeding movement has helped to improve the health and nutritional status of children in Bangladesh. Infant mortality has been reduced by half during this period.

Table 2. Findings from the Bangladesh Breastfeeding Surveillance Study: National Prevalence of Breastfeeding

INDICATORS	1 st Round July– August 1998	2 nd Round February 1999	3 rd Round July 1999	4 th Round February 2000	5 th Round August 2000	6 th Round February 2001	7 th Round December 2002	8 th Round July 2003
Exclusive breastfeeding children 4–6 months old	23.0%	21.2%	21.7%	26.4%	30.7%	41.9%	47.0%	35.1%
Initiation of breastfeeding within 24 hours	53.8	62.0	84.0	90.0	91.2	86.0	88.1	96.0
Colostrum feeding	88.0	86.9	84.0	92.0	83.4	77.7	96.0	98.0
Prelacteal feeding	81.3	78.0	84.0	77.7	81.4	88.2	79.0	72.3
Expressed breast milk knowledge	38.0	37.8	52.0	43.2	50.0	60.0	69.0	81.0

Source: Bangladesh Breastfeeding Foundation

Other child health programs in Bangladesh, including those addressing immunization, diarrheal disease, and Vitamin A capsule distribution, have individually and collectively contributed to better health and nutrition in Bangladesh. Breastfeeding programs contributed directly to the success of these programs.

The low-cost breastfeeding program that arose from a national policy decision in Bangladesh is an example of a successful initiative undertaken by professionals and development agencies working in partnership with the government for the welfare of children and women.

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CASE STUDY #2

MOBILIZING DEMAND FOR MATERNAL AND NEONATAL TETANUS IMMUNIZATION: REACHING WOMEN IN PAKISTAN

By Bruce Rasmussen and Nabeela Ali

“It is not possible for government only to work on projects like this...[N]ongovernment organizations...can persuade people and educate people...[T]here should be collaboration with nongovernmental organizations, donors, planners, [and] policymakers...”

Dr. Abdul Malik Kasi, Former Federal Minister for Health, Pakistan, regarding MNT immunization (from interview with Save the Children, 2002)

Pakistan has the third highest number of neonatal tetanus deaths globally, after India and Nigeria. This is hardly surprising given that nearly 80 percent of newborns are born at home, often without the benefit of clean delivery practices. Most pregnant women receive inadequate antenatal care and lack skilled assistance at delivery. Only about half of all women of childbearing age show serological evidence of adequate immunization against tetanus.¹ Consequently, in 1999 alone, tetanus killed nearly 22,000 newborns and countless mothers in Pakistan.²

In 1989, the World Health Assembly called for global maternal and neonatal tetanus (MNT) elimination, which was defined as fewer than 1 newborn case per 1,000 live births in every district of every country. In 1999 there were still 57 countries that had not eliminated neonatal tetanus, leading to renewed commitment and global efforts by UNICEF, the World Health Organization, the United Nations Population Fund, and others to reach the target by 2005. A major component of the Global MNT Elimination Program, led by UNICEF, is to immunize at least 80 percent of all

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women of childbearing age in high-risk districts or subdistricts with three properly spaced doses of tetanus toxoid (TT). This provides several years of immunity for these women and their newborns. MNT elimination can be maintained over time by routinely vaccinating pregnant women and by programs to ensure clean delivery practices.

Eliminating MNT is an enormous challenge for Pakistan. In 1997, when planning for MNT elimination began in earnest, more than half the districts in the country, 57 at the time, were identified as having pockets of high risk, based on reported cases of neonatal tetanus and on low rates of child immunization coverage. These high-risk areas included nearly five million women of childbearing age, most of them living in

inaccessible and socially conservative communities. The sheer number of women to be reached with three successive doses of TT was a challenge to the Ministry of Health (MOH) and its partners in terms of mobilizing funds and human resources.



Photo: Ayesha Villani (copyright by Save the Children)

The overall goal of SNL's social mobilization campaign was to position MNT vaccination as a means to achieve safe motherhood and have healthier babies.

In early 2001, the government of Japan contributed 15 million doses of vaccine, and Pakistan prepared to undertake a vaccination campaign. Save the Children's Saving Newborn Lives (SNL) initiative joined with the MOH, UNICEF, the World Health Organization, and the Japan International Cooperation Agency to help implement the program. Planners were immediately confronted with the question of how to overcome social barriers to vaccinating unmarried women and married women who were not pregnant. For years Pakistan's immunization program had focused on vaccinating pregnant women with two doses of TT, and even this had been less than successful. A campaign to give three doses of TT to all women of childbearing age would be much more difficult, if not impossible. Based on Save the Children's global expertise in community-based

health interventions, including some initial success with community mobilization for improved women's health at the district level in Pakistan, SNL took on the project of creating demand among at-risk women. This effort addressed a key gap in Pakistan's MNT elimination program, which until then was primarily focused on the logistics of making the vaccination available.

SNL's demand creation strategy achieved groundbreaking results. The three rounds of MNT immunization conducted in 2001–2002 reached a total of 4.2 million women of childbearing age, well over the international standard of 80 percent. Lady health workers (LHWs) were trained and deployed as vaccinators in large numbers for the first time, establishing a reliable connection between the healthcare infrastructure and at-risk women with limited access to healthcare. Through careful monitoring and evaluation of the communication strategy, the SNL team obtained reliable feedback that led to immediate program improvements and provided guidance for future campaigns.

The demand generation strategy, which used a marketing approach to generate consumer demand, had four broad steps: research, development and testing of messages and materials, implementation, and monitoring and evaluation.

FORMATIVE RESEARCH

Gathering accurate and relevant information from women and household and community decision makers was the foundation of this approach. Formative research was conducted in two randomly selected districts in each of the country's four provinces, ensuring representation from a wide spectrum of ethnic groups. Nine target audiences were identified, and specially trained staff of local nongovernmental organizations (NGOs) conducted 72 focus groups. The groups explored participants' knowledge, attitudes, and behaviors related to MNT. Key topics included the potential misperception of a link between TT injections and contraception; beliefs and practices related to women's access to services; and immunization "campaign fatigue," especially with regard to ongoing polio eradication efforts.

The information gathered from these focus groups was useful for overall program planning as well as for developing specific messages and strategies to increase awareness and demand for MNT immunization. It became quite clear that a door-to-door campaign, conducted by female vaccinators, would be needed to effectively reach most women. Furthermore, it would not be enough simply to raise demand among women themselves—fathers and husbands, mothers-in-law, community leaders, religious leaders, and teachers would all need to be mobilized in support of the campaign.

MESSAGE DEVELOPMENT

Using data from the formative research, the social mobilization team took an innovative approach in support of a very challenging health policy. A marketing and communications specialist, working along with one of the country's leading commercial advertising firms, provided technical assistance, while consulting regularly with the program planners (mainly staff of the MOH, UNICEF, and the World Health Organization) to ensure that program objectives were being met. The message development and material design process was carefully conducted and highly creative, and it involved the entire team. A variety of slogans and images were created to convey compelling life-style benefits of the vaccine. A unifying logo and color scheme were created. A set of printed materials and accessories was produced, each piece designed and tested to communicate specific messages to each target audience, including husbands, fathers, and religious leaders.

The overall communication theme was designed to position MNT vaccination as a means to achieve safe motherhood and have healthier babies. The primary image associated with the campaign was an attractive young woman receiving an injection from an LHW. The poster message proclaimed, "Tetanus is a life-threatening disease, but it can be easily prevented!" Instructions for when and where to get vaccinated were included on the poster. Other materials carried the slogan, "Tetanus immunization: for mother's health and baby's survival."

Communication materials included posters and leaflets for public display and distribution; large banners to place over street intersections and immunization centers; folders with information leaflets for religious and community leaders; another set of innovative materials in a folder for distribution at girls' schools; a kit for LHWs and other health workers, including a card for each vaccinated woman to keep as a record of completed immunizations; and distinctive scarves and caps for female and male healthcare workers to wear during the immunization campaign. Detailed implementation guidelines about the MNT elimination program and a video docudrama were also produced for use in training LHWs.



Poster: *Save the Children* US/Pakistan Field Office

*Effective use of posters, flyers, and other materials was critical to the success of *Saving Newborn Lives*' social mobilization campaign in Pakistan.*

IMPLEMENTATION

Implementing the communication strategy in 57 districts was a daunting challenge. Materials had to be pre-positioned at district and subdistrict health facilities. District health managers and their teams needed to be oriented to use the materials effectively. Community leaders and networks of community activists required mobilization in support of the campaign. Materials and messages had to reach girls' schools.

All of these tasks required the close cooperation of the MOH, SNL, and UNICEF. District health teams were the key to ensuring effective dissemination of materials and messages to the farthest corners of every district. Orientation meetings were held in each province and included LHW team leaders from each of that province's target districts. Resource persons then visited each district to conduct meetings with community leaders and give support to the district health team's preparations.

During the 2 or 3 days just prior to MNT immunization activities in each district, local mosques promoted the campaign. In cities and towns it was also common to find mobile vans and other vehicles circulating from street to street announcing the campaign by loudspeakers. These methods for making public announcements are common throughout Pakistan, and their use in this campaign demonstrated effective mobilization of religious leaders and community activists.

MONITORING AND EVALUATION

In order to monitor the effectiveness of the demand generation strategy, SNL conducted a rapid assessment following the first two doses of immunization, which were given 1 month apart at the beginning of the program. Hundreds of people, representing each of the nine target audience categories identified for the initial formative research, were surveyed in randomly selected target districts in each of the four provinces. The data collected generated several recommendations that led to intensified support for the communication campaign at the district and subdistrict level. For the third round of immunizations, conducted 6 months after the second

round, a coordinator for each district was identified and district health staff members were given an additional orientation.

Monitoring also highlighted the popularity of the MNT video docudrama. Program planners became interested in televising the 13-minute docudrama, as well as a 45-second television advertisement, produced by the advertising agency on a pilot basis. Earlier concerns about raising demand nationally, without the capacity to meet that demand everywhere, were becoming of less concern with the deployment of thousands of LHWs as vaccinators. The MOH therefore provided funds for broadcasting both the docudrama and the advertisement, which appeared on prime-time television leading up to the third round of vaccinations.

PROGRAM EXPANSION

The fact that more than 80 percent of the five million women targeted in the MNT immunization program were successfully reached with three doses of vaccine was an enormous encouragement to the MOH and its partners. The challenge had been met, and there was widespread recognition that a dynamic partnership, including SNL's demand creation strategy, had contributed to this success.

A decision was made to expand the program to cover the entire population, not just high-risk pockets, of the initial 57 districts, along with several additional districts. This would extend coverage to an additional 10 million women of childbearing age. The MOH, UNICEF, and SNL agreed to continue their partnership for demand generation in this scaled-up program. During 2002 the first two rounds of the second phase were implemented, with coverage rates once again exceeding the 80 percent target. Round three was conducted in mid-2003.

CONCLUSION

Although Pakistan has not yet achieved MNT elimination, more than 12 million women of childbearing age, in the highest risk areas of the country, have received protective MNT immunization. There is no doubt that many maternal and newborn deaths have been averted by this campaign. Community-based research influenced not only the communication strategy, but also overall program implementation. Due to the quality and success of the social mobilization strategy demonstrated in the early stages of the program, the government increased its own spending to further support demand-creation activities.

It is essential, of course, for Pakistan to follow up this successful campaign, which has given several years of immunity to millions of women and their newborns—with increased efforts to ensure effective, ongoing routine MNT immunization as well as cleaner delivery practices. Only the combination of these measures will result in achieving and maintaining MNT elimination throughout Pakistan.

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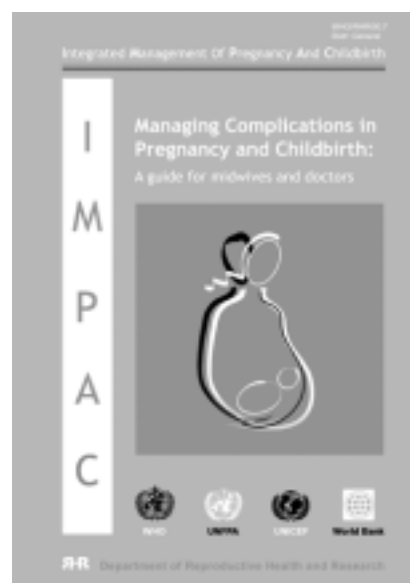
CASE STUDY #3

USING INTERNATIONAL GUIDELINES TO SUPPORT NATIONAL POLICY IN MATERNAL AND NEWBORN HEALTHCARE

By Sandra Crump

One of the ways that national governments solidify and communicate their commitment to safe motherhood and newborn health is through their national policy and service delivery guidelines, which outline a management and service delivery approach for achieving specific standards of care in healthcare facilities. In developing these guidelines—and the facilities and providers to support them—policymakers at the national level generally look to expert opinion and international consensus regarding practices and models that have been proven effective in other countries. The collection, synthesis, and publication of internationally endorsed maternal and newborn healthcare practices can therefore provide an important support and catalyst for policy change at the national level. International guidelines can provide both a focus for national policy dialogue and development and a technical reference to help ensure that national policies follow current scientific evidence and thinking.

This case study describes how the international guidelines in the World Health Organization's (WHO's) manual *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* (MCPD) have influenced policy development in countries where JHPIEGO and



Cover: World Health Organization

WHO's *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* establishes international standards for evidence-based maternal and newborn healthcare.

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the Maternal and Neonatal Health (MNH) Program have been working to increase the use of skilled care for women and newborns and increase maternal and newborn survival. The *MCPC* manual was published as part of WHO's Integrated Management of Pregnancy and Childbirth (IMPAC) series, the technical component of WHO's Making Pregnancy Safer strategy aimed at reducing maternal and perinatal mortality and morbidity and improving maternal and newborn health.

Policymakers have used the manual as

- A tool to help build consensus regarding the need for policy change,
- A reference in the development of national policy and service delivery guidelines,
- A model for a new national guidelines document,
- A guide in the development and standardization of national training curricula for maternal and newborn healthcare providers, and
- A training and practice manual at the service delivery level to promote the use of evidence-based practices in maternal and neonatal healthcare.

The experience with the *MCPC* manual shows the broad reach that international resource materials can have in supporting policy development and implementation, and has paved the way for similar work with other international guidelines documents.

FILLING THE NEED FOR INTERNATIONAL GUIDELINES FOR MATERNAL AND NEWBORN HEALTHCARE

In the late 1990s, WHO began working with several collaborators, including JHPIEGO, to develop a series of resource manuals that describe best practices in maternal and newborn healthcare based on scientific evidence and global experience about what works to save women and newborns during pregnancy,

childbirth, and the postpartum period. WHO and its collaborators envisioned these manuals not just as practice manuals, but as a set of global documents that would support national ministries of health in developing and modifying their national policy and service delivery guidelines and in producing and disseminating new national documents that are based on internationally endorsed practices.

The first of the manuals, *Managing Complications in Pregnancy and Childbirth*:

WHO's Integrated Management of Pregnancy and Childbirth series includes three manuals:

- *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors*
- *Pregnancy, Childbirth and Newborn Care: A Guide for Essential Practice*
- *Managing Newborn Problems: A Guide for Doctors, Nurses, and Midwives*

A Guide for Midwives and Doctors, was published by WHO in 2000. JHPIEGO's MNH Program experts worked closely with WHO to develop the manual. The manual's technical content is based on the recommendations of numerous WHO technical committees, evidence from systematic reviews from the Cochrane Database, and the consensus of a group of international experts in maternal and newborn healthcare in low-resource settings. Under WHO's direction, and with the input and endorsement of the United Nations Population Fund, UNICEF, and the World Bank, the manual was extensively reviewed by a variety of reproductive health experts and endorsed by the International Confederation of Midwives and the International Federation of Gynecology and Obstetrics.

Since the manual's initial printing in 2000, JHPIEGO has distributed more than 13,000 copies of the English version of the manual, and WHO has distributed thousands more. The manual has also been made available on the WHO Website and on JHPIEGO's ReproLine® Website. More than 4,600 visits were made to the manual's pages on ReproLine between February 2002 and April 2003. In addition, the manual has been translated into at least 10 languages, including Dari, French, Laotian, Mandarin, Mongolian, Russian, Spanish, and Vietnamese.

USING THE MANUAL TO PROMOTE POLICY CHANGE: A STRATEGIC APPROACH

Since the publication of the *MCPC* manual, WHO and the MNH Program have been working to ensure that the manual is used to motivate and inform changes in national policies related to safe motherhood. The process of developing and modifying national policy and service delivery guidelines is a complex one, often beginning with efforts to improve training and standardize services, rather than with efforts to develop policy. Once sufficient interest in improvements in training and services has been generated, consensus around the need for standards of care may grow, leading to the creation or revision of service delivery guidelines and, finally, national policy documents.

To facilitate regional and national adoption of the recommendations in the *MCPC* manual, WHO has convened meetings in every one of its regions to provide countries an opportunity to understand the evidence basis of the recommendations, debate the major changes in obstetric and midwifery practice, and adapt the recommendations to the particular needs of the regions. These meetings have brought together key stakeholders from countries in each region (including national ministries of health, professional organizations, educational institutions, regulatory bodies, and donors), and have resulted in rapid commitment at the national level for adoption of the manual. The MNH Program has been involved directly in three of these regional meetings and provides support to countries as they translate and adapt the manual. The French and Spanish editions of the manual resulted from these meetings, and many countries have produced adaptations (e.g., Indonesia) or translations (e.g., Afghanistan and Laos). UNICEF has also adopted the manual for its programs in South Asia and Africa.

To facilitate adoption of the standards articulated in the manual, the MNH Program produced several documents: a strategy paper (*Implementing Global Standards of Maternal and Neonatal Healthcare at the Healthcare Provider Level: A Strategy for Disseminating and Using Guidelines*), which explains how national policy documents and service delivery guidelines are created and implemented; a learning resource

Developing and implementing national policy and service delivery guidelines is a multiphase, nonlinear process that usually includes the following parts:

- Building political will through stakeholders
- Establishing national advisory group
- Drafting of guidelines
- Validating guidelines
- National endorsement
- Implementation plans

package, which focuses primarily on knowledge and skills for antenatal, childbirth, and postpartum care in preservice education programs that prepare skilled providers; and “Guidelines for Technical Adaptation and Translation of *Managing Complications in Pregnancy and Childbirth*,” a set of step-by-step instructions for both the process of getting national support for adaptation of the manual and the process of making technical changes to the material.

The MNH Program has put the manual at the center of both its approach to training skilled providers in essential

maternal and neonatal healthcare practices and its strategy for influencing national policies that support safe motherhood, focusing in particular on the development and implementation of national standards and guidelines for maternal and newborn healthcare. The Program has worked with ministries of health and other stakeholders on the creation of new national documents and on revising existing documents to reflect the *MCPC* manual’s standards. The Program has also worked to build momentum for policy change at the national level by promoting the use of the *MCPC* manual’s standards in national training curricula and by incorporating the standards into its competency-based training approach. Promoting the use of evidence-based practices helps to generate interest in standards of care and the will to implement policies and guidelines to support them.

The examples described here illustrate how the manual has been used both to strengthen policy documents and to catalyze the policy process in MNH Program countries and beyond.

A Tool for Policy Dialogue and Consensus Building among Stakeholders

In countries that are revising or developing their national norms and protocols, building consensus around proposed changes to existing national standards helps to ensure that stakeholders take ownership of the new policies and support their implementation. In several countries, the *MCPC* manual has provided a basis for comparison and a focal point for discussion among policymakers about needed changes to national norms and protocols.

In Honduras, for example, the MNH Program helped to organize and facilitate a meeting in 2001 at which a multi-institutional and interdisciplinary group of stakeholders discussed inconsistencies between the international standards in the *MCPC* manual and the country's norms and protocols for women's healthcare, and began developing a consensus document to reflect their agreement on a new set of standards. In March 2002, a technical group appointed by the Ministry of Health reviewed and accepted most of the recommendations that were based on the international standards in the *MCPC* manual, and these recommendations were incorporated into the consensus document. The consensus document was then approved, and the national norms and protocols were updated to reflect the newly agreed-upon protocols. Dissemination of the updated norms and protocols began in December 2002. This process has been critical to the continuation of clinical training, curriculum development, and performance and quality improvement in hospitals in Honduras.

A Technical Reference for National Policy Development

Some ministries have used the *MCPC* manual as their primary technical reference in the process of developing new national policies for maternal and neonatal healthcare. Bolivia, for example, used the concepts in the *MCPC* manual as the basis for Ministerial Resolution 0496, which officially adopts evidence-based maternal and neonatal healthcare practices as the national standard in government and private healthcare facilities throughout the country. The resolution mandates 18 improved practices for maternal and neonatal healthcare, including active management of the third stage of labor, an important clinical intervention for preventing postpartum hemorrhage. Ministerial Resolution 0496 was passed in October 2001, and the MNH Program in Bolivia and the Ministry of Health agreed to be responsible for disseminating the new practices through healthcare facilities, providers, and professional organizations.

In Guatemala, where there is increasing interest in gathering and understanding the evidence for clinical approaches in maternal and neonatal healthcare, the MNH Program assisted the Ministry of Health in revising, updating, and validating the national reproductive health norms, based on the technical information in the *MCPC* manual. National norms and protocols for antenatal care, childbirth, postpartum care and immediate care of the newborn, and management of complications have all been updated and revised based on the evidence-based standards in the manual. As part of the effort to institutionalize these standards, Guatemala has distributed the *MCPC* manual nationally. In addition, the Ministry of Health has formally adopted the *MCPC* manual as the technical reference manual to be used during maternal and newborn complications.

A Model for National Service Delivery Guidelines

The *MCPC* manual was developed as a prototypic global manual that can be translated or adapted for use, in whole or in part, within the framework of the needs, resources, and priorities of specific countries. National ministries of health

use the manual to produce materials and resources specific to their needs while ensuring that their national materials are up-to-date and clinically sound.

In Indonesia, the MNH Program supported the development of a new national document, *Buku Panduan Praktis Pelayanan Kesehatan Maternal dan Neonatal* (or “Practical Guidelines for Maternal and Neonatal Health”), which was modeled after the *MCPC* manual and published in 2001. *Buku Panduan* is adapted for field conditions in Indonesia and has been endorsed by an array of stakeholders. The adapted manual has been used to change existing safe motherhood standards and guidelines, including the national standards for midwifery practice. In addition, WHO has adopted *Buku Panduan* as one of the cornerstones of the national Making Pregnancy Safer strategy in Indonesia. The Indonesian obstetric and gynecology association has promoted and supported all efforts to make the *Buku Panduan* the national standard for maternal and newborn healthcare, and key senior officials from the Ministry of Health have made public declarations supporting the use of the material. The adapted manual is already widely used in the Indonesian healthcare system. The MNH Program has distributed 70,000 copies through workshops, professional health associations, and training activities conducted by the MNH Program and its partners in Indonesia.

Developing National Training Curricula

Because national curricula set the standard for the training of maternal and neonatal healthcare providers, working with national governments to develop new curricula and to incorporate evidence-based practices into existing curricula has been an important focus of the MNH Program’s policy activities. The *MCPC* manual has been an excellent resource in this process.

In Nepal, where the national government has implemented a 15-year National Safe Motherhood Plan, the *MCPC* manual served as a technical resource document in the creation of a national safe motherhood training strategy. The strategy was approved in 2001 and will be implemented over the next several years to guide the development of a competency-based training system for preservice and inservice training. In addition, national training curricula for auxiliary nurse-midwives and maternal and child health workers, two key cadres of health workers providing maternal and neonatal healthcare at the district and subdistrict level, were developed in 2002 using the *MCPC* manual as a guide.

The *MCPC* manual was used in Zambia as the basis of new clinical protocols, which in turn formed the basis of a revised national curriculum for registered midwifery schools. The curriculum was revised and learning materials were developed in 2001. Both were pilot-tested in 2002, and evaluation and approval are expected to be complete in 2003. Once the curriculum is adopted nationally, all of the midwives who graduate from Zambia’s three registered midwifery schools will be trained in the new practices. Similarly, in Afghanistan, the MNH Program and its collaborators used the *MCPC* manual as a key reference in designing training courses to support short-term training for midwifery students whose training at the national Intermediate Medical Education Institute was cut

short when the Taliban assumed power. The guidelines in the manual are also being incorporated into the revised standard national curriculum for midwifery training and are being promoted as appropriate standards for all obstetric training and practice in the country.

Building Momentum for Change at the Service Delivery Level

The *MCPC* manual is also being used to inform larger audiences of providers about evidence-based standards. Generating interest among providers ultimately contributes to the need and demand for changes in standards and guidelines, both locally and nationally.

In partnership with the Columbia University Averting Maternal Death and Disability (AMDD) Program, the MNH Program used the *MCPC* manual to develop an emergency obstetric care curriculum. With funding from AMDD, the MNH Program used the curriculum to train teams of providers from Afghanistan, Bangladesh, Bhutan, India, Nepal, and Pakistan in emergency obstetric care. The curriculum will be the standard by which all emergency obstetric care services—in 39 countries and 55 projects globally—will be supported under the AMDD program. In several of these countries (e.g., Bangladesh, Bhutan, and Nepal), the *MCPC* manual has become a standard text for medical students.

In Burkina Faso, the *MCPC* manual has become the centerpiece of the training strategy for maternal and neonatal healthcare providers. The MNH Program's expert trainers in Burkina Faso have helped to generate widespread interest in and demand for the manual, and have used the international standards in the manual in writing a new inservice training curriculum for courses in the Koupéla district. A French translation of the manual was launched in Burkina Faso in March 2003. Enthusiasm at the service delivery level has helped to drive the policy process at the national level, where the manual was used in revising the maternal and newborn health section of the country's reproductive health policies, norms, and protocols. In addition, Burkina Faso and 16 other West African countries have recently developed an emergency obstetric and neonatal care curriculum, based on the *MCPC* manual's recommendations, for use in preservice institutions.

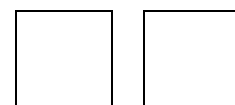
FUTURE WORK WITH INTERNATIONAL GUIDELINES

An internationally approved and recognized document such as the *MCPC* manual can be used not only to promote a global standard for maternal and neonatal care at the service delivery level, but also to support the creation of policies that ensure the quality and availability of healthcare services for mothers and newborns. Based on their recent experience with the *MCPC* manual, WHO and the MNH Program anticipate that two new manuals in the IMPAC series—*Pregnancy, Childbirth and Newborn Care: A Guide for Essential Practice* (developed by WHO) and *Managing Newborn Problems: A Guide for Doctors, Nurses, and Midwives* (developed by WHO and JHPIEGO)—will have an equally important role to

play in securing and supporting future national policy commitments to maternal and newborn health. These manuals will form a rich resource for safe motherhood and newborn health programs to draw on as they work to promote the development of national policy based on current, internationally endorsed, evidence-based standards for care.

CONCLUSION: INGREDIENTS FOR SUCCESS

The strong collaboration between WHO and the MNH Program has produced a global document that is serving as a catalyst for the rapid national adoption of global standards for maternal and neonatal healthcare. The success of the effort has been enhanced by the endorsement and buy-in of international agencies and professional bodies such as UNICEF, the United Nations Population Fund, the World Bank, the International Confederation of Midwives, and the International Federation of Gynecology and Obstetrics. In addition, strong regional support and ongoing incountry support for the adoption of global standards and guidelines has generated momentum for these changes. Finally, the dissemination of tools (such as the *MCPC* learning resource package and the guidelines for adaptation and translation of the manual) to support the adoption and use of the *MCPC* manual have helped national ministries use the manual, within the framework of their own countries' needs, resources, and priorities.



BUILDING COMMITMENT:

Action for
Policy Change

SHAPING
POLICY
for Maternal and
Newborn Health

CASE STUDY #4

USING ADVOCACY TO PROMOTE LOCAL COMMITMENT TO MATERNAL HEALTH IN INDONESIA

By Lucy Mize

In 1999, Indonesia's Public Law 22 became the legal basis for decentralized ministerial roles and regulation in all sectors of government. This formal decree stipulated the terms of the country's decentralization efforts, including the devolution of authority to the district and provincial levels. The Ministry of Health of Indonesia had already been at the forefront of decentralization, adopting practices and policies that support local authority as early as 1987. In July 2000, following the passage of Public Law 22, the Ministry of Health conducted a 3-day workshop aimed at developing commitment among district heads (or *Bupati*) and setting local budget allocations for health. By December 2001, however, local allocations for health were still significantly lower than required, and there was a growing need for advocacy at the district level to bring health issues to the attention of local policymakers.

Devolution of decision making to the districts created an opportunity for JHPIEGO's Maternal and Neonatal Health (MNH) Program to conduct advocacy activities on behalf of maternal health in Kuningan, West Java. These efforts have resulted in increased local support and financial resources for maternal health and survival. This case study describes the advocacy strategy and process used, the outcomes of the MNH Program's efforts, and some of the lessons learned along the way.

ADVOCACY STRATEGY AND PROCESS

The MNH Program developed an advocacy strategy and process that built on an existing network of support in Kuningan and took advantage of existing systems for exerting influence on public decisions in Indonesia. The steps in the process

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included building an advocacy coalition, identifying leaders who could contribute to a positive climate for social change, and communicating messages about maternal survival to key decision makers.

Building a Coalition of Influence

Since Public Law 22 delegated responsibility for funding local health programs to the *Bupati*, the MNH Program in Indonesia has made a concerted effort to include the *Bupati* in its advocacy efforts throughout the country. The *Bupati* of Kuningan was elected in 1998, after serving as a village head and as an official at the subdistrict level. With a background in public policy, he understood advocacy as a tool for social change. Because he was the head of the local branch of Red Cross Indonesia, he knew that more than 60 percent of the area's blood supply was used to treat bleeding during childbirth, so he understood the severity of maternal complications. He was a decision maker who supported the MNH Program's interventions by turning his awareness into action. The advocacy strategy in Kuningan, therefore, focused on expanding the network of support around the *Bupati*.

Coalition building began with the creation of a chapter of the White Ribbon Alliance in Kuningan in early 2002. This alliance works to promote maternal survival, and its membership is drawn from the ranks of Nahdlatul Ulama and Muhammadiyah, two of Indonesia's largest Islamic social networks. One of the natural leaders in the White Ribbon Alliance of Kuningan was the public relations officer of the local chapter of Red Cross Indonesia. Like the *Bupati*, he was familiar with the importance of timely blood donations in ensuring maternal survival. Because of his close association with the *Bupati*, through both his professional network and family connections, he was able to play an important role in securing increased financial support for maternal health.

IDENTIFYING LEADERS

Social networks in Indonesia—such as those created by kinship, political party membership, and university alumni affiliations—provide a strong source of support and influence on public decision making. Recognizing this, the MNH Program involved the Minister of Women's Empowerment, who was a member of the same political party as the *Bupati* (the Golkar Party), in its advocacy efforts. As a member of the Cabinet, the Minister of Women's Empowerment also carried inherent authority. Central-level government figures in Indonesia command enormous respect and work very well in the role of agent for social change, in part because they can use their authority to impart legitimacy to local decision makers. The Program also sought out other agents who were credible and who wanted to promote maternal survival. For example, the former Minister for Human Rights agreed to become a spokesman for the White Ribbon Alliance. Because he was a well-respected leader, his participation ensured that the *Bupati* would look favorably on MNH Program activities.

Although the *Bupati* was the focal point of the advocacy efforts, the Program also solicited the involvement of members of the local parliament, who had fiscal approval authority under the new law and who could pose challenges to the *Bupati*'s decision making. The selection of local decision makers to target was left primarily to members of the White Ribbon Alliance and to the local community facilitators, since they understood the formal and informal power alliances.

Communicating about Safe Motherhood Issues and Needs

The last step in the process was to create communication channels for relaying advocacy messages to the identified leaders and others. Using a four-step process called DEED (discussion, education, evidence, and decision making), the MNH Program disseminated advocacy materials to local Ministry of Health counterparts, local leaders from the religious community, and health services providers in Kuningan in late 2001 and early 2002. A forum was held in March 2002 to bring these groups together to discuss maternal health issues and the need for maternal survival systems in the MNH Program's intervention areas. The forum included village facilitators who had been trained in community participation techniques.

A series of motivational meetings held in April and May 2002 included speakers such as the former Minister of Human Rights. At these meetings, men whose wives had died in pregnancy and childbirth told their stories. These personal stories brought a human dimension to the issue of maternal mortality. As a result, authorities were encouraged to develop support systems, such as financial systems and transportation.

Throughout this period, at meetings, seminars, and other events, the MNH Program provided global evidence about approaches that work to promote maternal survival and how those approaches could be adapted to the Indonesian context. Evidence was presented on four main features of the MNH Program's framework for birth preparedness and complication readiness:

- Identification of blood donors
- Identification of transport
- Saving money to pay for the birth
- Notification of authorities of the birth and the plan for assistance and referral during childbirth



Photo: Luthfi Hasan

Local journalists interviewing the Minister of Women's Empowerment at a ceremony for a desa siaga (alert village) in Kuningan in April 2002. During the Minister's visit, the Bupati of Kuningan issued the 10-point platform on maternal health.

Between March and June 2002, as the final step in the DEED process, the MNH Program team met with legislators to outline their request of the decision makers—that is, increased public resources dedicated to maternal survival.

NEW RESOURCES FOR CHILDBIRTH: A SUCCESSFUL ADVOCACY OUTCOME

Before these advocacy efforts, the *Bupati* of Kuningan had allocated health resources primarily for the control of leprosy and parasitic infections. However, in response to the MNH Program's advocacy efforts, the *Bupati* formally declared in May 2002 a 10-point platform for maternal health, which specified that every woman should receive

- Complete information about the benefits of healthy pregnancy and safe childbirth;
- The same services as every other woman, without regard to ability to pay;

Drawing on the *Bupati's* Fund for Emergency Care for Childbirth

Ibu E'eh is a 24-year-old resident of Cieruh village in Kuningan. Her husband works as a stall trader in Jakarta, which is a 4–5 hour drive away, and he returns home only when he has collected enough money to give to his family.

In February 2003, Ibu E'eh gave birth to the couple's second child. She had chosen the local midwife, Bidan Nur, to attend her birth at home. During the birth, she experienced premature rupture of the membranes. Bidan Nur found that the baby was malpositioned for birth, so she referred Ibu E'eh to Pabuaran hospital. There, with the help of a resident ob/gyn, Ibu E'eh gave birth to a baby girl through normal childbirth.

Ibu E'eh used the money she received from the *dasolin* (the *Bupati's* fund) to help defray the cost of her emergency transportation to the hospital and additional funds from the community's savings plan and her own savings to meet the additional expenses for her care.

- Her choice of position for childbirth (semi-sitting, hands and knees, squatting, or sideways position);
- Safe and effective services;
- Privacy during consultation and examinations;
- A guarantee that personal information will be treated confidentially;
- Humane, appreciative, and attentive services;
- Comfort during services;
- A guarantee that services will be continuous and sustainable; and
- The freedom to share her opinion and ask for the services she needs.

The *Bupati* also allocated 400,000,000 Rupiah (approximately \$40,000) for a revolving fund (called the *dasolin*) to pay for the care of a skilled provider for women in childbirth and for the treatment of

complications. About two-thirds of the funds (\$25,000) were designated for use in 17 villages in MNH Program intervention areas. These villages had completed the steps necessary to become a *desa siaga* (aware village). The steps include having a

transportation system in place, identifying blood donors, establishing a savings fund to help people pay for care for maternal complications, ensuring that the village has a midwife who is trained in updated normal childbirth skills and interpersonal counseling, and establishing a notification system to record births and inform village leaders so they are prepared to trigger the complication readiness system if necessary.

The remaining funds were designated for other parts of the district that were adopting the MNH Program's interventions but that did not receive the Program's financial or technical assistance. Overall, the resources would be used in 72 villages in the Kuningan district.

SETTING UP THE FUND: NEW CHALLENGES

The new fund established by the *Bupati* guaranteed that resources would be allotted for maternal health. It was a major step forward in ensuring that access to care would not be denied because of a lack of funding. Along with this new resource allocation, however, came new challenges in managing access to the fund and sustaining the fund over time.

The resources designated for the MNH Program areas were divided equally between the 17 villages. At the outset, \$1,600 was taken from the fund to pay for membership cards and plaques for each village to document their participation and increase awareness of the fund. Committees were set up in each village to manage the funds, and the funds were set up in a variety of ways. Most communities chose not to keep the money in banks. Hospitals in Indonesia often request a cash advance before they treat complications, so communities need the fund to be immediately accessible. In some villages, the village chief was entrusted with the fund, while in others the midwife kept the money.

All women of reproductive age are expected to be eventual users of the fund. To help sustain the fund, women are asked to contribute 500–1,000 Rupiah (\$0.5–0.10) per month. Some villages have also examined fundraising schemes such as adding a small tariff to all electricity bills or selling donated rice, chickens, or coconuts.

Eligibility for use of the fund is broad and is not based on income. Each pregnant woman's needs are anticipated in advance, and an appropriate allocation is made for her care. For example, if a woman has had a previous child by cesarean section, the community anticipates that she will need another cesarean section and will determine her allocation accordingly. Families are expected to pay back the money they use over a 3-month period after the birth.

Although this fund is dedicated to maternal health needs, it is a ready source of cash for villages in which there are competing demands for resources. In some villages, people have tried to access the fund to pay for the ongoing treatment costs of tuberculosis. In others, they have tried to access the fund as seed money for agricultural enterprises. In addition, some village committee members have tried to access the fund for their personal needs because no safeguards were in place to control access. A continuing challenge has been ensuring that funds are not siphoned

The Dasolin: A Guarantee of Care

Ibu Inayah, the 25-year-old wife of a driver for an Islamic boarding school in Wage Village of Kuningan, gave birth to her third baby in January 2003 at Wijaya Kusuma Hospital. The baby was delivered by cesarean section because of hemorrhaging.

Normally, hospitals in Indonesia are reluctant to incur costs for emergency operations if they do not receive payment upfront. Ibu Inayah had received 75,000 Rupiah from the *dasolin* (the *Bupati's* fund), and she had some money from her savings plan. But neither of these would cover the cost of her emergency care. Nevertheless, she was able to access emergency healthcare because among the additional benefits of the *dasolin* is a letter of guarantee and credit to the hospital. This allowed her to negotiate a repayment scheme stretched out over a 5-month period to repay the expenses that her savings plan and the *dasolin* did not cover.

off for other uses, leaving villages without the means to secure care for women who need it.

One of the lessons learned in this process has been that, in order for financial systems to be sustained, public accountability must be established to ensure that funds continue to flow to the targeted beneficiary (in this case, pregnant women). In addition, systems must be in place to ensure that funds are replenished in a regular fashion.

REPLICATING THE STRATEGY THROUGH PARTNERSHIPS

The MNH Program's advocacy strategy succeeded in securing political support and resources for maternal health in Kuningan. As a result of the Program's outreach to partners such as UNICEF, elements of the Program's advocacy approach are also being used to secure local policy and resource

commitments elsewhere in West Java and Indonesia. For example, UNICEF will spend \$55,000 in five districts in West Java to create *desa siagas*, using parts of the MNH Program's materials and approaches package. The Program's advocacy efforts have also spurred a greater awareness and willingness within the West Java government to allocate resources for health. For example, a bill passed in March 2003 allocates \$20,000 for health to each of 700 villages in West Java. One of the primary promoters of the bill, who is both the chairperson for the White Ribbon Alliance of West Java and the head of the West Java branch of the Indonesian Midwifery Association, advocated for 20 percent of the funds to be earmarked for maternal health. To ensure that this level of resource allocation continues, the MNH Program will monitor and document expansion and replication efforts and will continue its outreach to the Vice Governor of West Java, who is charged with implementing the health resources policy. The MNH Program will also provide ongoing support to the White Ribbon Alliance and use the power of the alliance to maintain maternal health funding gains.

In 2002, the MNH Program developed a White Ribbon Alliance in Banten, a new province created in 2000. The Banten alliance, which is now being supported by UNICEF, is actively promoting maternal health. The provincial health officer had realigned budget allocations and decreased funds for maternal health information. However, because of increased advocacy by the White Ribbon Alliance, the province is going to replicate the birth preparedness and complication readiness activities of a model *desa siaga* in 87 villages in Pandeglang, Banten, through 2005.

A partnership between AusAid's Women's Health Project, the MNH Program, USAID's Healthy Indonesia 2010 program, the Helen Keller Foundation, and the local government in Nusa Tenggara Barat province has resulted in the formation of another White Ribbon Alliance and greater interest from the local government in funding interventions to promote maternal survival.

LESSONS LEARNED AND RECOMMENDATIONS

The MNH Program's advocacy strategy in Kuningan was to build a network of support for maternal health around the decision maker who could influence local policy. The Program's experience suggests that customized advocacy at the district level, building on political assessments made by local promoters of maternal health, provides the best results for increased fiscal resources in a decentralized system. In addition to the support of the *Bupati* himself, the involvement of other influential local and central-level leaders was critical. Central government members still have a role to play in lending legitimacy to local decision making. Their endorsement of local decisions is helpful, because systems in Indonesia are still hierarchical and leaders at the top generate acceptance and respect. Finally, advocacy efforts must be embedded in the institutional context of local government and not dependent on personal interests. The community facilitators, who come from 17 villages in Kuningan, are now working on policy and regulations for ongoing resource allocation to maternal health. This will govern any future resource allocation from the *Bupati* or local government.

Based on the MNH Program's experience in Kuningan, the following recommendations can be made for other programs that are using advocacy to influence local policy for maternal and newborn health:

- Make “what is in this for me” clear to the primary decision maker. In Kuningan, the incentive for the *Bupati* was receiving accolades from top members of government, which he viewed as important to his political career.
- Embed efforts in the local context. The MNH Program used villagers from Kuningan to make the impact of maternal mortality very personal and relevant within the environment. This prevented politicians from using the rationale that “it doesn't happen here” as an excuse for non-action.
- Define the competition and then find key characteristics that will make the program or issue stand out. In Kuningan, other health issues, while urgent, did not result in loss of life or have as strong an impact on families as maternal health.
- Finally, find solutions and frame the demand for resources within the context of fixing a community-identified problem. Local governments often are reluctant to support solutions that appear to be too broad or not within the manageable interests of the local government. The MNH Program used the framework of birth preparedness and complication readiness to define a very specific set of interventions that needed government support. By anchoring advocacy efforts

within the community and by making very clear the contributions that a leader can provide, a positive situation was created. Communities increase access to local resources and leaders can follow finite steps with clear benefits.

CASE STUDY #5

NEPAL'S NEONATAL HEALTH STRATEGY: A POLICY FRAMEWORK FOR PROGRAM DEVELOPMENT

By Neena Khadka, Judith Moore, and Chris Vickery

With the highest newborn mortality rate in South Asia, Nepal has a pressing need to make neonatal health a high priority for its health system. There are 800,000 births each year in Nepal, and 30,000 babies die before they are a month old. By and large, newborn healthcare in Nepal is viewed in the shadow of maternal health, and national policies and development plans only address newborn health issues—if they address them at all—in the context of safe motherhood. Prenatal and neonatal outcomes are considered inseparable from women's health status. However, appropriate care for the newborn continues beyond the mother's pregnancy and delivery. Thus, policies guiding the introduction of newborn care in communities and facilities must be established in concert with those for maternal care and yet treat newborn health separately.

Newborn care interventions are neither widely understood nor widely practiced in Nepal's communities and health system. Among the country's largely rural population, traditional attitudes and practices dictate newborn care. For instance, breastfeeding is nearly universal, but 50 percent of newborns receive prelacteal feeds, and initiation of breastfeeding is often delayed. Tetanus, pneumonia, and hypothermia, all of which are highly preventable, are primary causes of newborn deaths.



Photo: Thomas Kelly (copyright by Save the Children)

By focusing on the central practice of home-based delivery, it may be possible to introduce routine newborn and maternal care, and awareness of possible maternal and neonatal complications and their causes, at the family and community levels.

Neena Khadka is SNL Program Manager for Nepal and Judith Moore is SNL's Regional Health Advisor for Asia. Chris Vickery is an independent consultant.

In Nepal, 82 percent of births take place in the home, usually in the absence of a skilled attendant. By focusing on the central practice of home-based delivery, it may be possible to introduce routine newborn and maternal care, and awareness of possible maternal and neonatal complications and their causes, at the family and community levels. These interventions require the establishment of a “chain of care” linking families and communities with the national healthcare system.

INTRODUCING NEWBORN HEALTH

Saving Newborn Lives (SNL), an initiative of Save the Children USA that is supported by the Bill & Melinda Gates Foundation, set up its program in Nepal in 2001. One of SNL’s first actions was to engage a team of local consultants to produce a situation analysis of newborn mortality, health, and healthcare in the country. The main purpose of the situation analysis (published as *State of the World’s*

Newborns: Nepal [2001]) was to establish the strategic objectives for SNL’s program. But the presentation of the draft situation analysis at a strategic planning workshop held jointly with the Ministry of Health (MOH) and SNL in October 2001 raised the need for a formalized National Neonatal Health Strategy (NNHS) in Nepal.

Nepal’s Safe Motherhood Strategy acknowledged the need for newborn healthcare as a goal in its results log frame, and specifically recommended that newborn health be addressed in a separate document. In February 2002, the MOH asked SNL to provide technical assistance in formulating the NNHS, and SNL agreed to oversee the creation of a Newborn Working Group and assist in the development of a working document describing a neonatal health strategy.

Lessons Learned

A local situation analysis produced by national researchers is an effective tool for

- Defining the parameters of a problem,
- Lending credibility to the strategic process through a factual base and constructive recommendations, and
- Focusing on objectives that stakeholders can take part in and endorse.

Advocacy based on sound data (from research, surveys, and other information) can build partnerships and momentum for joint initiatives.

THE NEWBORN WORKING GROUP: 5 MONTHS TO A POLICY STRATEGY

The first meetings of the Newborn Working Group began in May 2002, mediated by a consultant who worked with the group to keep discussions focused. The 18 working group members were selected on the basis of their experience with the issues, and included specialists and opinion leaders from the MOH and the fields of neonatology, safe motherhood, public health, community mobilization, and research. The group was kept small to avoid the possibility of its becoming “a talking shop for one person from every office.”

One of the principal achievements of the Newborn Working Group was bringing together obstetric and safe motherhood experts with child survival experts and

representatives—from the MOH to tertiary health facilities, from international nongovernmental organizations (NGOs) to national NGOs. This diverse mix was essential to establishing new and creative approaches to newborn health issues and laid the groundwork for new lines of communication. Another important decision was to include retired people who had a lifetime of experience to draw on and who were highly respected and capable of devoting the necessary time to the process.

The Newborn Working Group was given the challenge of producing the NNHS in 5 months—by the end of 2002. Despite initial skepticism on the part of some of the stakeholders as to what could be accomplished in such a short timeframe, the Newborn Working Group achieved its mission on schedule.

In the early stages, the working group members had differing opinions on what shape the newborn health strategy would take. One indication of their collective uncertainty was their premature focus on details, such as the layout and format of the strategy document, before any content had been created. To help the group address the content of the strategy, early discussions focused on what the group thought the strategy should *not* be. They agreed that the NNHS would *not* be

- a wish list,
- a textbook,
- a set of national care standards, or
- a detailed operational document.

This discussion helped to demystify the process of strategic thinking, and the working group then moved on to defining what NNHS *would* be: a summary of the agreed-upon and evidence-based priorities for newborn healthcare. The group also identified its target audience (government ministers, donors, and so on) to ensure that the language and content would be accessible to an informed lay reader.

To refine the product further, the working group again used the process of elimination

Components of Nepal's National Neonatal Health Strategy

Nepal's Neonatal Health Strategy is built on the following factors:

- A focus on community-level interventions, while addressing all levels of Nepal's health system
- Recognition that newborn care interventions must be introduced within the context of traditional health practices
- Replication of successful models of home-based and community-based care, such as the SEARCH project's home-based newborn care in Gadchiroli, India

Lessons Learned

When developing a health strategy with a working group:

- Keep the working group small and focused, not broad and representational.
- Define objectives early to eliminate uncertainty and lack of focus.
- Secure early agreement on what the health strategy will achieve.
- Avoid duplication or overlap with other strategic plans.

to determine the priorities that they would not address. They drew up the national policy framework as the context within which the NNHS would be formulated. By identifying those areas in which strategies already existed or were in process, the working group was able to exclude some important but not germane issues, including perinatal health (covered in the Nepal Safe Motherhood Strategy), HIV/AIDS, and malaria.

WORKING GROUP OBJECTIVES

Having broadly defined the NNHS, the working group agreed to produce a series of position papers on key aspects of neonatal care in Nepal. The approach to selecting topics for the papers was discussed at length, and the following categories or themes were considered:

- Causes of neonatal death
- Interventions at specific levels of Nepal's health system
- Interventions by specific levels of health worker in Nepal
- Analyses of neonatal/child rights

Again, approaches were eliminated systematically. Members decided that there should be no separate position paper covering “the community” because it was the principal level of Nepal's health system addressed in all of the papers. (Because most rural communities are far from health facilities, health interventions must be introduced immediately and directly to people where they live.) They also concluded that potential interventions by different cadres of healthcare worker within the health system were important, and would be included in annexes. The working group decided that using a neonatal child rights approach (e.g., “the right to air” and “the right to warmth”) added an unnecessary level of complexity.

In the end, the group decided to prepare papers on the causes of neonatal death, as described in *State of the World's Newborns: Nepal*, and on three seminal cross-cutting themes: the normal newborn, breastfeeding, and danger signs. The eight topics for position papers were:

- Care of the newborn
- Breastfeeding and micronutrients
- Danger signs
- Asphyxia
- Low birthweight
- Sepsis
- Hypothermia
- Jaundice

After strategic discussions were concluded, the participants began writing position papers. Assigning representatives from different disciplines to work together resulted in innovative approaches to the issues and a strong sense of ownership among all participants. These papers were critical to subsequent discussions of issues and contributed significantly to early drafts of the NNHS. In effect, they were the scaffolding around which the NNHS structure was built.

The next step was to transform the position papers into a formal strategy. Through the next series of meetings, the working group members discussed and revised four drafts of the document.

Early in 2003, the NNHS was submitted to the MOH for consideration. By laying out the critical interventions for newborn health and identifying responsibilities for each cadre of healthcare worker, these directives chart a course for future newborn healthcare standards in Nepal. The NNHS received verbal approval from government policymakers, and the Family Health Division began the process of formalizing the strategy into an MOH policy document. Because the MOH now requires that all policy documents be published in Nepali, the NNHS is being translated and will be resubmitted to the MOH for final approval.

CONCLUSION

The work of the Newborn Working Group is complete. In less than a year, the group created the NNHS, the structure that supports national priorities for home- and facility-based care for newborns. The government's acceptance of this document has ensured that policymakers, service providers, ministries, private-sector organizations, and NGOs have a guide for implementing programs to improve neonatal health and survival in Nepal.

The process of transforming national policy into programmatic reality lies ahead. The success of this transformation will depend on long-term strategies for training all cadres of health professionals and behavior change initiatives that influence household behaviors and practices. These goals will be achieved in the context of the Safe Motherhood Subcommittee of the MOH's Family Health Division, while the sick newborn program will be linked to the Child Health Division. Representatives from the Newborn Working Group will work within these two divisions to implement the goals of the NNHS, reflecting the view that newborn health is the link between maternal and child healthcare.

Lessons Learned

Position papers are valuable to policy development because they

- Focus the enthusiasm of participants and engender ownership of the process,
- Shift discussion from the abstract to the concrete, and
- Build solidarity and teamwork.

CASE STUDY #6

ADVANCING THE AGENDA OF NEWBORN HEALTH POLICY AND PROGRAMS IN INDIA: THE ROLE OF A PROFESSIONAL ASSOCIATION

By J.P. Dadhich, Armida Fernandez, and Vinod Paul

India is a vast country of one billion people steeped in diverse traditions, beliefs, and faiths. Its multilingual, multiethnic, and multicultural character combined with advances in higher education and technology set it apart from other developing countries.

India faces an unparalleled health challenge. Each year, almost 26 million infants are born there, accounting for approximately 20 percent of the world's births. Although the neonatal mortality rate has declined in recent decades (from 78 per 1,000 live births in 1975 to the current level of 45 per 1,000), the toll of 1.2 million deaths each year is the highest of any country and accounts for nearly 30 percent of the entire global burden of neonatal deaths. More than two-thirds of all newborn deaths occur among low-birthweight infants in India.

This unacceptable rate of newborn mortality can be traced to the absence of appropriate care for women and newborns at the community level. Two out of three births take place at home, and skilled birth attendants assist only 42 percent of all deliveries. One in three neonates in India is born with low birthweight. Primary care for newborns is rudimentary, referral pathways are virtually nonexistent, and facilities are neither accessible nor geared to look after sick newborns. As a consequence, many families and communities have come to believe that poor survival of newborns is inevitable.

India's National Population Policy has set a goal to reduce the infant mortality rate to fewer than 30 per 1,000 live births by the year 2010 from the current rate of 66 per 1,000. Achieving this goal will necessitate bringing down the neonatal mortality rate

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to less than 20 per 1,000, a reduction of more than 50 percent, in less than a decade. The country is also committed to achieving the United Nations' Millennium Development Goal of reducing child mortality to one-third of the 1990 level by the year 2015, which mandates a major reduction in newborn deaths.

The National Neonatology Forum (NNF) in India has worked closely with the Indian government for more than 20 years on a wide range of initiatives to improve newborn health through policy, training, and education for healthcare providers in newborn care and research in community-based health for newborns. The long history of collaboration between this professional association and the government will reach a new high in the next 5-year phase of the national Reproductive and Child Health Program, to be launched in early 2004, in which comprehensive newborn health strategies aimed at converting the static graph of neonatal mortality into a fast-declining slope are expected to receive a major boost.

THE NATIONAL NEONATOLOGY FORUM: OBJECTIVES AND PROGRAMS

A handful of leading pediatricians working in the field of neonatology established the NNF in 1980, and set forth the following objectives:

- To encourage and advance the knowledge, study, and practice of the science of neonatology in the country
- To draw out recommendations for neonatal care at different levels
- To establish liaisons with other professionals concerned with neonatal care
- To assess the current status of electronic equipment being used in the country for perinatal care and promote indigenous manufacturing of equipment
- To develop a neonatal component of the curriculum for medical and nursing education
- To organize conferences, trainings, and workshops to promote neonatal care in the country

The dissemination of neonatal resuscitation skills is one of the NNF's leading programs. The Neonatal Advanced Life Support training initiative was launched in 1990, and a faculty of more than 150 was trained in a phased manner. They and others have conducted thousands of workshops on neonatal resuscitation in all parts of the country for nurses, general practitioners, pediatricians, and obstetricians employing the American Academy of Pediatrics protocol and using a hands-on approach with manikins. The NNF also recognizes the nationwide promotion of Kangaroo Mother Care as an important agenda for the next few years for which an action plan is being formulated.

NNF AND SUPPORT FOR NATIONAL PROGRAMS

Although the NNF began as an organization of pediatricians of tertiary care institutions to promote neonatology, it soon became a catalyst for advancing newborn *health* throughout the country, helping to expand newborn care beyond the nurseries in hospitals.

The NNF prepared the first set of recommendations on neonatal care in India in 1980. In 1982, a task force on minimum perinatal care, with participation from the NNF and the government of India, declared that, “Level I care will be imparted through the trained traditional birth attendants and female healthcare workers in the community.” In the years that followed, several members of the NNF worked with community-based projects on newborn care to train traditional birth attendants, health workers, and nurses, developing small hospital newborn care models, utilizing workers of the Integrated Child Development services for newborn care, and simplifying the technology of newborn care to suit low-resource settings.

By the early 1990s, the successful implementation of the Universal Immunization Program had led to a steep decline in neonatal tetanus and thereby a big drop in neonatal mortality. By then, the NNF had put newborn health firmly on the national agenda through sustained advocacy and its track record. As the national Child Survival and Safe Motherhood (CSSM) program was being formulated (1992–1997), the NNF recommended that essential newborn care (ENC) be included as one of the components of a child survival strategy (along with immunization, management of diarrhea and pneumonia, and vitamin A prophylaxis) for the first time. The NNF assisted the government in developing the ENC package (consisting of resuscitation, prevention of hypothermia and infection,

About the Neonatology Forum of India

The NNF currently has more than 2,500 members, including primarily pediatricians, but also a few nurses and others. It is led by a 10-member governing body, composed of elected and nominated members, and currently maintains 18 state chapters. In order to ensure progress on critical issues, the NNF has established subcommittees on subjects such as research, curriculum, nursing, equipment, and accreditation.

The NNF maintains the following programs and products:

- A quarterly periodical (the *Journal of Neonatology*)
- Numerous continuing education activities nationwide, including its annual convention
- A program of accrediting newborn units in India
- Technical guidelines on neonatal monitoring, equipment, primary care, communication strategies, ventilation, nursing, and other areas
- A monograph on traditional practices in newborn care
- Recommendations on undergraduate and postgraduate medical and nursing education
- Standard text and teaching slides on key topics on newborn care for medical students and physicians
- A module on essential newborn care for basic healthcare workers
- A network of 16 leading institutions, formed as the National Neonatal Perinatal Database in 1995, which provides hospital-based information on newborn morbidity and mortality and forms a nucleus for multicenter collaborative research. The network is now being supported by the Indian Council of Medical Research.

exclusive breastfeeding, and referral of sick newborns). The targets for ENC services in the CSSM program were district, subdistrict, and first-level facilities. The NNF contributed to the development of training materials and selection of essential equipment for ENC services, and its trainers were responsible for hands-on training and monitoring the introduction of operations in 30 districts.

In 1997, the CSSM program gave way to the Reproductive and Child Health (RCH) program, which combined the CSSM components with those of the family planning program. The child survival package, including ENC, remained the same, although the training extended to auxiliary nurse-midwives. The NNF was called upon to assist the government in operationalizing the ENC package in district, subdistrict,

and first-level facilities in 80 districts. A new set of training materials was developed and the RCH program was successfully implemented against a tight timeline. NNF faculty conducted 90 workshops and trained 3,600 physicians and nurses in 2000–2002 under this initiative.



Photo: Saving Newborn Lives; courtesy of the Bill & Melinda Gates Foundation

In the next 5-year phase of India's Reproductive and Child Health Program, to be launched in early 2004, the National Neonatology Forum and the government will launch comprehensive newborn health strategies aimed at converting the static graph of neonatal mortality into a fast-declining slope.

In the year 2000, at the request of the NNF, the Indian government agreed to observe a National Newborn Week during the week of 15–21 November each year. The first National Newborn Week was launched by the Honorable Prime Minister on 15 November 2000. This was a notable accomplishment in more than one way: (1) It signified the recognition of newborn health as a key national priority. (2) It reflected political commitment at the highest level. (3) It marked the government's recognition of the contribution and credibility of the NNF.

The NNF is actively networking with partners and stakeholders—including the national and state governments of India; international agencies such as WHO, UNICEF, and DFID; nongovernmental organizations such as the Breastfeeding Promotion Network of India; and professional bodies such as the Indian Academy of Pediatrics, the Indian Medical Association, and the Federation of Obstetrics and Gynecological Societies of India—to improve newborn care in the country.

For instance, the NNF is assisting the government, WHO, and UNICEF in adapting the Integrated Management of Childhood Illness (IMCI). The draft Indian version of IMCI is known as “Integrated Management of *Newborn* and Childhood Illness” (IMNCI) to highlight the neonatal component. The NNF is a member of the National Technical Committee on Child Health and is routinely consulted on policy and program issues. Likewise, many state leaders of the NNF are involved in different ways in assisting in the respective state governments in newborn care initiatives.

The NNF has been involved in the design of the second phase (2003–2009) of the Reproductive and Child Health program (RCH II). It is widely expected that RCH II will give a major boost to newborn health if home-based newborn care is implemented in much of the country.

The NNF has been a long-time champion of the groundbreaking study on home-based newborn care developed by the Society for Education, Action and Research in Community Health (SEARCH). The NNF was involved in assisting the SEARCH investigators in developing the ENC package and in endorsing the active treatment of sepsis with gentamicin injections given by village health workers. The NNF strongly advocates the dissemination and scaling up of the SEARCH model, and there is indeed a strong possibility that the SEARCH model of home-based neonatal care will be incorporated into India's RCH II.

CONCLUSION

The National Neonatology Forum has emerged not just as an advocate and not just as a catalyst, but also as a close partner of the government in promoting newborn health in India. This is a unique accomplishment for a professional organization, and it resulted from the NNF's sustained contribution in diverse domains ranging from policy to training, from technical assistance to research, from curriculum to equipment, and from networking to action. The credit for this success goes to the vision, teamwork, and commitment of NNF's leadership coupled with the zeal, activism, and effort of its members.

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CASE STUDY #7

NEW POLICIES, NORMS, AND PROTOCOLS IN BURKINA FASO: AN IMPORTANT STEP TOWARD IMPROVING MATERNAL AND NEWBORN HEALTHCARE

By Rebecca Dineen

National policies, norms, and protocols (PNPs) for healthcare set the stage for the provision of care—from the provider’s welcome to the client interview to the clinical exam and treatment and beyond. Current, evidence-based PNPs contribute to the quality of healthcare by establishing standards of care and telling healthcare providers what is expected of them and what they should do to deliver high-quality services at each level of the healthcare system. Norms and protocols are structured in such a way that health agents, midwives, nurses, and doctors all have appropriately outlined tasks for the level of care they provide.

Since 1999, JHPIEGO has worked with the Division of Family and Reproductive Health of the Ministry of Health (MOH) in Burkina Faso as a partner in its overall effort to update and implement new national PNPs for reproductive health. This case study describes this process with a focus on JHPIEGO’s participation, through the Maternal and Neonatal Health (MNH) Program, in reviewing and validating the PNPs for essential and emergency obstetric care—a critical element of the national safe motherhood strategy—and promoting the new PNPs in a district-level model system of care.

BACKGROUND

Burkina Faso is a landlocked country situated in the heart of West Africa on the southern fringe of the Sahara desert. Considered part of the Sahel region of Africa, Burkina Faso has few natural resources. The minimal rainfall in the north of the

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country limits the availability of food and, therefore, the nutritional health of the population. Burkina Faso's health and development indicators are among the worst in the world.

Since independence in 1960, Burkina Faso has remained one of the poorest countries in the world, ranking 169 out of 174 countries in the United Nations Development Program's 2000 Human Development Index. In 1998, more than 45 percent of the country's population lived below the poverty line. In 2000, life expectancy at birth was 45 years, infant mortality was 105 per 1,000 births, and gross primary school enrollment was only 40 percent. Maternal mortality rates are also extremely high: 484 maternal deaths per 100,000 live births in 1998.¹ Some organizations estimate the maternal mortality rate as high as 1,400 per 100,000 live births.²

Increasing infant and child mortality rates as well as the high maternal mortality rate point to probable deficits in maternal and newborn care services. Although the 1998 Demographic and Health Survey found that 59 percent of pregnant women have at least one prenatal visit, it also found that only 32 percent of women give birth in a health facility with a skilled provider and 11–12 percent of babies are born with low birthweight.

THE REVISION OF BURKINA FASO'S POLICIES, NORMS, AND PROTOCOLS

In 1998, the Burkina Faso Ministry of Health began updating and revising its reproductive health guidelines as part of an overall reproductive health initiative sponsored by USAID through its Family Health and AIDS (FHA) project. The revision of the PNPs followed several years of increasing commitment by the MOH to address the health status of the population and to decentralize health services to the district level (as part of an overarching government-restructuring program). One of the goals of decentralization is to expand access to maternal and child health services as part of the primary healthcare services network.

At a regional workshop that included policymakers and healthcare experts from four West African countries, including Burkina Faso, the FHA project shared tools for reviewing and revising national guidelines with participants. Participants also received a review of reproductive health policies (including the type of care provided by each cadre of providers) and a process and generic model for revising and disseminating PNPs.

Policymakers and experts from Burkina Faso designed the new Burkina Faso PNPs to include five volumes of information addressing all domains of reproductive health, including maternal health, child health, youth and adolescent health, men's health, and community involvement and support. Each of the volumes contains (1) policies that orient healthcare providers to national and international health priorities and justify interventions; (2) norms or service standards that describe the minimal acceptable performance in service delivery; and (3) protocols that describe precisely and chronologically the tasks required to meet the specified service standards.

In 2000, after receiving recommendations for changes to all sections of the PNPs, the MOH invited key technical experts to organize a national workshop for validation of the PNPs. These experts formed a technical committee and worked for 2 days to ensure consistency of the draft guidelines with the latest World Health Organization (WHO) recommendations. By the end of their first meeting, the technical experts agreed on the parts of the revised PNPs that warranted presentation and validation by the larger group of stakeholders.

Securing Stakeholder Input and Buy-In

In a 3-day meeting, the technical committee presented key elements of the PNPs and the proposed revisions to a group of 75 participants representing medical directors and reproductive health decision makers. During the meeting, the technical committee asked the group to make final decisions on controversial policies and protocols that had not been resolved. By the end of the workshop, the facilitators and participants had reviewed the changes to all five volumes of the PNPs.

Participants at the meeting agreed to a number of recommendations to revise the overall PNPs in terms of both content and the process for delivering healthcare services. Changes in process included adding an “analysis step” to all of the protocols, acknowledging the importance of analyzing all of the information gathered during a visit, and promoting a problem-solving approach to care provision. In addition, the group recommended including the concept of infection prevention and, where applicable, procedures for incorporating infection prevention in care for all patients.

REVISING AND TESTING THE PNPs FOR ESSENTIAL AND EMERGENCY OBSTETRIC CARE

The revision of the PNPs for essential and emergency obstetric care was conducted in tandem with overall revision process. After learning about the collaboration between JHPIEGO and WHO on a new global reference manual, *Managing Complications in Pregnancy and Childhood: A Guide for Midwives and Doctors (MCPC)*, the Ministry of Health of Burkina Faso asked JHPIEGO’s MNH Program experts to review the section of the maternal health PNPs that covered essential and emergency obstetric care. This was viewed as an important component in the implementation of Burkina Faso’s safe motherhood strategy, which had been developed in the early 1990s.

The MNH Program agreed to review the PNPs document and to use the guidelines to design a model system of essential and emergency obstetric care in one district—the Koupéla district. The MOH approved the proposed model along with an agreement that the approaches and tools used would be disseminated in other districts of Burkina Faso as well as in other countries of the region.

While partners in the FHA project were reviewing the other sections of the PNPs, the MNH Program performed its review of the standards for essential and emergency obstetric care and made recommendations to the MOH for changes to

bring the document in line with WHO's recommendations for maternal and newborn care. Changes made to the maternal health PNPs, based on the recommendations in the *MCPC* reference manual, included the following:

- Reducing the number of antenatal care visits to four
- Including attendance at all births by a skilled provider
- Abandoning assessment of pregnant women according to risk; acknowledging that all pregnancies are at risk
- Providing vitamin A supplements for low-birthweight babies
- Reducing the number of questionable medical interventions during labor, including routine shaving, enemas, and episiotomies
- Adding neonatal care to the volume on maternal health

These changes marked a critical first step to upgrading the quality of maternal and neonatal health services at every level of the Burkina Faso health system.

Feedback from Providers and Trainers: The Addition of the WHO Partograph

Burkina Faso's PNPs were finalized and approved in August 2000. By April 2001, providers and trainers were using the revised PNPs in the MNH Program's Koupéla district program sites and providing recommendations on the document to the MOH. The MNH/Burkina Faso expert trainers identified a significant shortcoming

in the PNPs when they began using the documents: The technical committee had not added the WHO's standard partograph—a critical tool for the management of labor—to the revised PNPs. Further research showed that few providers in Burkina Faso ever used, or even understood the value of, the partograph. In fact, more than 20 different versions of the partograph were available in Burkina Faso, causing confusion nationwide.



Photo: Marianne Elias

A newly trained midwife fills out a partograph at Koupéla district hospital.

The MNH/Burkina Faso program advisor wrote to the MOH to request that the current PNPs be updated with the WHO partograph. The proposal convinced the MOH to lead a national workshop to adopt the WHO partograph as the standard. The process of adopting the WHO partograph as the national standard included training 58 midwives and male birth attendants about the benefits of the revised partograph. After the training, the national teaching hospital in Ouagadougou also endorsed the use of the WHO partograph.

With official backing, MNH/Burkina Faso trainers and the Network for Prevention of Maternal Mortality developed a national partograph training module. The MOH

used the module to train a core group of 20 trainers from different regions. During the training, participants designed a national plan to train healthcare providers at all district and regional hospitals in the use of the partograph.

A Pocket Guide: A New Tool to Facilitate Use of the PNPs

By late 2001, the MOH had provided nine regional hospitals and two national hospitals with copies of the revised PNPs. The PNPs gave providers the information they needed to meet the new standards for reproductive healthcare, including emergency and essential obstetric and neonatal care. The density and length of the five volumes, however, made it difficult to use the PNPs in daily operations. As an alternative, the FHA project and the MNH Program proposed to design pocket guides for district-level service providers, including specific job aids for complex procedures. In November 2002, the MOH approved the recommendation, and eight faculty members, service providers, and MNH Program expert trainers began to develop the guide.

In early 2003, the FHA project educated regional health directors and district chief physicians on the use of the guide. MOH partners in reproductive health, including UNICEF, the World Bank, UNFPA, Family Care International, Save the Children, the MNH Program, and others, will support an orientation and dissemination of the pocket guides to district-level providers in late 2003.

SUPPORTING DISTRICT-LEVEL USE THROUGH TRAINING AND PQI

The MOH now had the opportunity to examine the impact of the revised PNPs on the quality of care through the MNH Program's model system of essential and emergency obstetric care. The model program is located in the Koupéla district, approximately 140 kilometers east of the capital city, Ouagadougou. This district has a population of 291,241, with approximately 66,522 women of reproductive age.³ MNH/Burkina Faso targets 13 health facilities and the communities surrounding these facilities. The health sites include a hospital with a surgical unit, one without a surgical unit, and 11 community health centers. Approximately 64 percent of women of reproductive age in the district live in the area surrounding these sites. The maternal and neonatal health indicators in the Koupéla district reflect the poor health conditions of the country.

As a first step to improving maternal and neonatal health in Koupéla, MNH/Burkina Faso held a performance and quality improvement (PQI) workshop with the district health management team (DHMT) using the revised PNPs as the standard for defining desired performance. Using the new recommendations from the PNPs, the team designed supervisory checklists and visit content that included critical evaluation steps for measuring improvements in the quality of care. The evaluation steps identified the extent to which providers were performing the following:

- Using an analytical approach to providing patient care
- Conducting prenatal consultations based on client needs

- Promoting birth preparedness and recognition of danger signs during pregnancy, childbirth, the postpartum period, and in the newborn
- Counseling women to help them choose their birth position
- Monitoring labor with the aid of a partograph
- Actively managing the third stage of labor to minimize hemorrhage
- Advising women to attend postnatal care followup visits in the first 6 hours, in 6 days, and in 6 weeks to prevent complications

The PQI workshop offered the DHMT an opportunity to review the new maternal health component of the PNPs and to analyze the most efficient process for their required quarterly supervisory visits. The DHMT went on to facilitate PQI workshops for 27 healthcare providers and 54 community health management team members in the district. During these workshops, they presented key components of the revised PNPs as the gold standard for care. Participants were then asked to identify discrepancies between the desired standard and their actual performance in maternal and neonatal healthcare. Through this PQI analysis, participants found low-cost solutions to the majority of the performance gaps.

Following the PQI workshops, two Burkinabé MNH Program expert trainers updated other providers in the standards in the new PNPs. During the training program, the experts certified 14 trainers and 16 supervisors. These core trainers have gone on to train 50 additional providers in the revised standards for essential and emergency obstetric care.

District-Level Impact of the PNPs

In the Koupéla district, providers in each of the 13 MNH Program facilities are now using the revised PNPs as their standards. Since 2002, the DHMT has conducted four supervisory visits at all program facilities. They found that 88 percent of the providers trained by the MNH Program were competent in using the revised PNPs. Current facility-based data show that antenatal care use in the facilities has increased from 66 percent of eligible women making visits in 2000 to 83 percent in 2002. Births attended by skilled providers increased from 36 percent in 2000 to 41.5 percent in 2002. The DHMT attributes the increased use of services to using the PNPs to influence performance at the facility level, improve supervision, and raise service provider competence and community awareness.

LESSONS LEARNED

The process of revising the PNPs required an enormous contribution and commitment of time from all partners supporting reproductive health. The leadership of the MOH's Division of Family and Reproductive Health was critical to the success of this effort. The process by which the PNPs were reviewed and revised was highly collaborative. The Division of Family and Reproductive Health engaged a wide range of players including key decision makers within the MOH, all regional

hospital directors, and development partners such as UNFPA, UNICEF, WHO, the World Bank, and USAID through the FHA project and the MNH Program.

Dissemination is an essential part of the implementation process for new policies, norms, and protocols. Before the printing of the second draft of the PNPs in June 2001, the MNH Program used the draft to develop generic maternal and neonatal health training materials for Burkina Faso. Providers in the Koupéla district, where the MNH Program works, were trained using these generic materials. Once the PNPs were finalized and printed, the Koupéla district was the first district to implement the newly revised protocols for essential and emergency obstetric and newborn care through expanded training and implementation of service delivery standards in select sites. Training and other program interventions also helped to identify important gaps in the PNPs, such as the need for a national partograph based on the WHO standard. In addition, when trainers and providers found that even the one maternal health volume of the PNPs was too cumbersome to use, a pocket guide was developed to make dissemination easier.

In spite of the progress made, there are still a number of challenges to be addressed in the dissemination and application of the PNPs. First, the PNPs will have to be progressively updated to reflect current evidence from WHO and to respond to needs and resources in Burkina Faso. Second, many of the health structures in Burkina Faso are in poor condition and lack the materials and staff to implement the new standards. Even in ideal conditions, maintaining quality will be challenging due to the frequency with which health personnel are transferred. Finally, disseminating the PNPs nationwide will require a large investment of resources, which poses a challenge to the MOH.

CONCLUSION

Burkina Faso has taken a critical step in the process of improving the quality of maternal and neonatal healthcare by updating its policies, norms, and protocols for essential and emergency obstetric care. The revised PNPs establish a framework for healthcare delivery and give providers the direction they need to improve their performance and the quality of care. The participatory process employed by the MOH in revising the PNPs ensured stakeholder buy-in and ownership of the new national standards for care.

The district-level model system of essential and emergency obstetric care developed by the MNH Program provided an ideal context for the process of implementing and testing the PNPs because it:

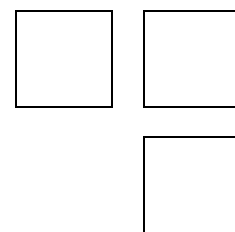
- Allowed trainers and providers to test the PNPs and make recommendations for further changes;
- Provided a forum for identifying areas for further strengthening the PNPs, such as the inclusion of the WHO partograph;
- Tested the applicability of the PNPs to an actual service delivery setting;

- Enabled the development of a PQI process to implement the new standards; and
- Created a venue for training trainers and providers in the updated practices.

UNICEF, a primary partner in the MNH Program in Burkina Faso, is working with the MOH to expand the Koupéla district program. In addition, Family Care International has been involved in supporting the reproduction and dissemination of the PNPs in the Ouargaye district and in orienting providers to their use. Other partners are committed to disseminating the pocket guide nationwide. As demonstrated in the Koupéla district, using the revised PNPs to standardize care and improve training for healthcare professionals can improve access to and the use of appropriate care for mothers and newborns.

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PROGRAM LEARNING:

Informing
Policy Design

SHAPING
POLICY
for Maternal and
Newborn Health

CASE STUDY #8

TRAINING AND AUTHORIZING MID-LEVEL PROVIDERS IN LIFE-SAVING SKILLS IN KENYA

By Ann Thairu and Karen Schmidt

When emergency obstetric complications occur, they tend to be sudden, unpredicted, and serious, and they can quickly become life-threatening for the mother, the infant, or both. For women in Kenya—most of whom deliver outside the hospital—timely access to appropriate medical care in the event of complications can mean the difference between life and death.

In the past, only medical doctors had the training and authorization to provide life-saving emergency obstetric care in Kenya. Mid-level providers, such as nurses, nurse-midwives, and clinical officers, may not have been explicitly forbidden from providing this care, but neither were they authorized or trained to offer it. As a result, because of a shortage of doctors—especially in rural areas—women seeking help at health facilities often found mid-level providers who wanted to help, but did not know how to manage complications.

In 2000, Family Care International (FCI) brought together key stakeholders, including the Ministry of Health (MOH), the Nursing Council of Kenya, the Kenya Obstetrics and Gynaecology Society, and various training institutions, to try to solve this problem. By developing and piloting an inservice training curriculum in life-saving skills for mid-level providers, the stakeholders demonstrated that these professionals, when properly trained and supervised, could competently and safely manage many obstetric complications. This process resulted in an implied shift in government policy, and the MOH took the lead in developing the draft curriculum and supported the training. The Ministry's Division of Reproductive Health is now working to finalize and scale up the inservice training program, and to enact a clear, explicit policy authorizing mid-level personnel to provide high-level care to manage obstetric complications.

Ann Thairu is National Coordinator, FCI/Kenya. Karen Schmidt is an independent consultant. Ellen K. Brazier, FCI Program Director for Anglophone Africa, contributed to this case study.

BACKGROUND

Most maternal and newborn deaths are the result of obstetric complications, and most deaths and disabilities could be prevented if women had access to a skilled attendant during delivery. A skilled attendant is a professional provider trained to proficiency in key skills, who must be able to manage normal labor and delivery, recognize the onset of complications, perform essential interventions, start treatment, and supervise referrals as needed.¹

In Kenya, estimates of maternal mortality range from 590 to 670 per 100,000 live births. Women in Kenya have a 1 in 36 chance of dying during pregnancy and childbirth, and maternal causes account for 27 percent of deaths to women ages 15 to 49.² It is estimated that only 42 percent of births in Kenya take place with a skilled attendant, and the overall proportion of deliveries attended by such healthcare personnel has fallen in recent years.

A key reason for the low rate of deliveries in facilities is staff shortages, especially in rural areas. Although Kenya has one doctor per 7,700 residents—one of the highest ratios in sub-Saharan Africa—there is a shortage of doctors in the public sector and a serious shortage in rural areas. Most doctors (84 percent) and about half of all clinical officers and nurse-midwives are stationed in urban areas, where only 16 percent of Kenya's population lives.

Nurses and midwives represent the largest pool of key healthcare personnel in Kenya: there are an estimated 24,600 nurses and midwives, compared to 3,300 medical doctors and 2,300 clinical officers. Although deployment of nurses and clinical officers is skewed toward urban areas, the ratios for nurses in rural areas are far more favorable than those for physicians.³ Traditionally in Kenya, nurses and midwives have staffed the maternal and child health and family planning clinics and maternity units in health facilities, especially in rural areas. Thus, they are on the frontline in the reduction of maternal mortality. Nevertheless, many mid-level providers lack essential knowledge and obstetric care skills, and few have received refresher or inservice training in reproductive health or obstetric care, including managing obstetric complications. In addition, health facilities lack equipment, supplies, and drugs for adequate maternity care, and referral networks, which are essential for managing obstetric emergencies, are poorly developed, if they exist at all.

Because higher-level medical cadres are not accessible to most women in Kenya, the country is facing a compelling need to expand the skills of mid-level providers to enable them to manage obstetric complications. Recent experience in Kenya has already demonstrated that, with appropriate training and supervision, mid-level healthcare professionals could expand their roles and effectively perform higher-level procedures. In the 1980s, for example, nurses in Kenya were not permitted to administer intravenous drugs. However, in many clinical sites and situations, they have performed this task routinely. Nurses have also been trained to insert intrauterine devices and Norplant, and to provide postabortion care using manual vacuum aspiration. Physicians and communities increasingly recognize that nurses are capable of providing a higher level of care in many situations. Given these

circumstances and the urgent need to reduce maternal deaths in rural areas, in 2000, the MOH, the Nursing Council, and the medical community began exploring the possibility of tapping mid-level providers for training in life-saving skills in obstetrics.

INTERVENTION PROCESS

In early 2000, the MOH and FCI, with financial support from the U.K. Department for International Development/Eastern Africa, launched a demonstration project to improve access to high-quality maternal health services in Garissa District in North Eastern Province, a remote and extremely disadvantaged region bordering Somalia and Ethiopia. The pilot project had two main objectives: to improve the accessibility and quality of essential obstetric care, especially the management of obstetric complications, and to raise awareness in communities to increase the use of health services. Because no national training curriculum in life-saving skills existed in Kenya, an essential first step was to develop a competency-based training program that addressed the main causes of maternal mortality in the country.

A collaborative process was undertaken to develop the first national inservice training curriculum for life-saving skills in Kenya, and to pilot the training in Garissa District. The project enlisted a range of stakeholders to ensure broad-based support for the curriculum and for efforts to train mid-level staff.

Stakeholders included representatives of various professional associations, such as the Kenya Obstetrics and Gynaecology Society, the Kenya Medical Association, the Midwives Chapter of the National Nurses Association of Kenya, and the Clinical Officers Association. Other stakeholders included the Nursing Council of Kenya, the Department of Obstetrics and Gynaecology of the University of Nairobi, Kenya Medical Training College, and the Chief Nursing Officer in the MOH. Colleague agencies such as JHPIEGO, Population Council, and UNFPA were invited to participate in the curriculum development process.

The curriculum development committee first reviewed internationally available curricula, including those developed by the American College of Nurse-Midwives, the World Health Organization, and UNICEF/Somalia and the Ministry of Health of Uganda. The following 10 modules were selected as relevant to Kenya:

- Overview of safe motherhood in Kenya
- Quality antenatal care
- Monitoring the progress of labor
- Episiotomies and repair of lacerations



Photo: Dr. Solomon Orero

Life-saving skills trainees at Garissa Provincial General Hospital showing their emergency tray

- Prevention and treatment of hemorrhage
- Management of shock
- Resuscitation
- Prevention and management of infection
- Vacuum extraction
- Management of other obstetric emergencies

Postabortion care (PAC), which is a critical life-saving skill, was not included in the draft curriculum because a range of PAC modules were being used in Kenya, and the Ministry of Health was in the process of synthesizing these into a national PAC curriculum. Therefore, the project focused on developing a life-saving skills curriculum into which an additional module on PAC could be integrated later.

After the draft curriculum was developed, it was pretested in two trainings of staff from Garissa District in mid-2000 and mid-2001. Followup supervisory visits to providers showed that the skills were being used. The most frequently used skills were those in managing antepartum and postpartum hemorrhage, severe anemia, retained placenta, and high blood pressure (pre-eclampsia). Staff reported particular satisfaction in being able to manage cases of retained placenta and hemorrhage, and they also reported that the training in resuscitation skills had enabled them to reduce neonatal deaths. This training effort demonstrated the enormous potential of making motherhood safer by empowering mid-level healthcare personnel to provide a high level of obstetric care.

Following the supervisory visits, a 2-day national-level Review and Planning Meeting was held in May 2001. This meeting served as an opportunity to discuss findings from the followup supervisory visits, to solicit additional input on the draft curriculum from various stakeholders, and to identify specific steps that should be taken to finalize the curriculum after the end of the pilot project. The meeting also provided an opportunity to discuss strategies for implementing inservice training in life-saving skills nationwide, to select an appropriate strategy for Kenya, and to identify the steps required to implement the strategy.

MOVING FORWARD

Since the success of the demonstration project, stakeholders have begun moving forward on strategies for expanding the inservice training nationwide, for eventually incorporating life-saving skills into preservice curricula, and for other changes that would enhance the ability of mid-level staff to provide high-quality obstetric care. Steps that are currently under way include the following:

- At the Review and Planning Meeting in 2001, stakeholders agreed that a decentralized training strategy would be more effective than a national strategy in imparting life-saving skills to sufficient numbers of healthcare personnel. A range of steps were identified for ensuring the effective implementation of a regional

training strategy, as well as a consistent and standard approach to planning and conducting training sessions.

- Four more training sessions were held for additional staff from North Eastern Province, as well as providers in Coast Province and in Rift Valley Province (the latter by UNFPA). These trainings served as an additional field test for the inservice curriculum, which is expected to be finalized by late 2003.
- The MOH, the Nursing Council of Kenya, and others are discussing adding life-saving skills to the preservice training curriculum for nurses. PAC skills, including manual vacuum aspiration, are already being introduced into preservice training for nurses.
- The MOH and other stakeholders have initiated a process to develop clinical protocols on obstetric care. These tools, which would clearly outline steps for recognizing and managing obstetric complications, would help providers at all levels offer more effective care.
- Preliminary discussions are under way to explore whether nurse-midwives might also be trained to conduct cesarean sections. Some are already being trained to administer anesthesia. Mid-level healthcare providers have been trained to conduct cesarean sections in other parts of Africa where shortages of physicians and anesthetists are a major constraint to the provision of comprehensive essential obstetric care.

FROM PRACTICE TO POLICY

The key stakeholders in Kenya fully support efforts to train mid-level providers in life-saving skills. The demonstration project was successful, and trained nurses and clinical officers are effectively providing these services at their workstations. However, the policy related to these changes remains unclear, and changes in nursing responsibilities have occurred over the years without any accompanying legislation authorizing these providers to perform expanded functions. In fact, there is no legislation that specifically outlines nurses' responsibilities.

The MOH has acknowledged a lack of clear, detailed service delivery and policy guidelines for life-saving skills, and indeed for most areas of reproductive health. The Ministry's *National Reproductive Health Training Plan 2000–2004* notes that reproductive health curricula "are being developed by various agencies, but since there are no national standards for most new technical areas, there is no consistency about what is being taught to whom" (p. 25). The same document also states that revising policy guidelines could expand the types of services offered by non-physicians, particularly nurses. "For example, in order to effectively expand safe motherhood services, the MOH will need to examine whether it is appropriate for nurses to be trained in more complicated life-saving skills, like MVA, C-section, etc." (p. 25).

A Life-Saving Skills Success Story

Mrs. Amina Abdi was in labor and had eclampsia when she was admitted to a provincial referral hospital. A midwife who was trained in life-saving skills received Mrs. Abdi, who had three children and was in labor with the fourth. The midwife stabilized and assessed the condition of the mother and the baby. She found that Mrs. Abdi was in established labor, with frequent strong contractions, a fully effaced cervix dilated at 6 centimeters, an adequate pelvis, and a regular fetal heartbeat. The management plan she recommended was to stabilize the eclampsia appropriately, augment labor with an oxytocin drip, sedate the mother, and rupture the amniotic membranes.

A visiting ob/gyn examined Mrs. Abdi and disagreed with the midwife's plan. He thought the patient should have had an emergency cesarean section. The midwife maintained her position, pointing out that Mrs. Abdi was a multiparous woman in advanced labor and that she was more likely to deliver in less than the anticipated 4 hours with active management of the labor. In the end, the midwife was right: Mrs. Abdi delivered a live baby within 2 hours.

Lessons Learned:

- Providers trained in life-saving skills can assess women in labor accurately and make appropriate plans of management.
- Providers trained in life-saving skills can manage eclampsia effectively.

Although there is currently no explicit policy authorizing nurses to perform life-saving functions, several other developments demonstrate a *de facto* shift in government policy:

- The *Implementation Plan for the National Reproductive Health Strategy 1999–2003* recommended that providers be trained, “including equipping them with life-saving skills and updates in Emergency Obstetric Care at various levels” (p. 7).
- The *National Reproductive Health Training Plan 2000–2004* sets a clear focus on life-saving skills: In the foreword, Dr. Richard O. Muga, the Director of Medical Services, states that “using the ‘Risk Approach’ and ‘Life-Saving Skills Approach,’ the plan goes beyond the identification of gaps and isolates the critical skills required by the trainees at all levels in order to make them competent in handling cases such as obstetric emergencies” (p. v).

In addition, the MOH is developing a clear policy on life-saving skills for mid-level providers. Dr. Josephine Kibaru, Head of the Division of Reproductive Health, has stated that she is working to develop a document that would detail which services mid-level staff can provide, with proper training and supervision.⁴ Once signed by the Director of Medical Services and distributed to the provinces, such a document would become official Ministry policy.

All of the stakeholders agree that, given the high burden of maternal mortality in Kenya, especially in disadvantaged and remote areas, it is essential that mid-level providers be equipped to provide emergency obstetric care. Although considerable progress has been made, policymakers and stakeholders need to continue moving forward to improve and clarify standards for obstetric care, and to create an enabling environment to allow safe motherhood to become the norm in Kenya.

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CASE STUDY #9

CALIRED: A NATIONAL STRATEGY FOR IMPROVING MATERNAL AND NEWBORN HEALTHCARE IN GUATEMALA

By Anjou Parekh and Oscar Córdón

The CaliRed accreditation program in Guatemala is a national program to improve maternal and neonatal healthcare services using a performance and quality improvement (PQI) approach. *CaliRed*, or “quality network,” provides the framework and tools to implement, measure, and evaluate improvements at facilities that deliver essential maternal and newborn healthcare services. Under *CaliRed*, if a facility achieves 85 percent or more of its established criteria for quality, it receives official Ministry of Health (MOH) accreditation as a “quality site” for essential maternal and neonatal care. When enough facilities in a particular district meet the quality standards, the MOH awards accreditation to the entire health service network in that district. The *CaliRed* process is a powerful example of how a PQI approach supported by government policy—with full participation of key stakeholders, including community members who access those services—can strengthen maternal and neonatal healthcare services nationwide.

SOCIAL AND POLITICAL CONTEXT

Guatemala has among the poorest health outcomes in all of Latin America, due in part to its prolonged civil strife and widespread poverty. Its largely rural indigenous population lives in some of the most difficult conditions found in Central America. Less than half of the Guatemalan population has access to health services, and the combination of poor health indicators and underutilized public health facilities suggests that the type, quantity, and quality of services being provided by the government do not meet the needs of the population.

Anjou Parekh is formerly a JHPIEGO Program Development Officer in Guatemala. Oscar Córdón is the Country Representative for the MNH Program in Guatemala. Lucrecia Peinado, Project Management Specialist, Office of Health and Education, USAID/Guatemala, contributed to this case study.

After 36 years of civil war and armed conflict, Guatemala transitioned to peace with the signing of the Peace Accords late in 1996. The Accords called for major social sector investments in health, education, and other basic services to reach segments of the population that had never been adequately served, and required the full participation of the indigenous people in local and national decision-making. The Peace Accords also called for the reduction of maternal mortality in Guatemala as one measure of socioeconomic progress. Furthermore, the Social Development Law (*La Ley de Desarrollo Social*), ratified in 2001, clearly established the state's obligation to "reduce the rates of mortality with emphasis on women and infants."

In response to the Peace Accords, the government of Guatemala introduced the Integrated System for Health Care (*Sistema Integrado de Atención en Salud*), or SIAS, in 1997. SIAS aimed to extend basic services to impoverished rural, indigenous populations with little or no access to healthcare by contracting nongovernmental organizations to provide and administer healthcare services. In 2000, the government established a national health council and a reproductive health program that outlined specific objectives to reduce maternal mortality. And, in 2002, the government passed a law that mandated the involvement of municipal governments, civil societies, and community members in interventions that aim to reduce maternal mortality.

It is within this context that the Guatemalan government sought new and innovative ways to improve maternal and newborn healthcare across the network of healthcare facilities. A ministerial agreement signed in November 2001 established *CalíRed* as Guatemala's national strategy for improving the quality of maternal and newborn healthcare.

CALIREd: SUPPORT FOR GOVERNMENT COMMITMENT TO SAFE MOTHERHOOD

Given the terms highlighted in the 1996 Peace Accords, the Guatemalan MOH began exploring the possibility of implementing a PQI accreditation model to ensure standards for quality across healthcare facilities.

Recognizing the priorities of the MOH and the need to tailor strategies to meet those priorities, JHPIEGO's Maternal and Neonatal Health (MNH) Program team in Guatemala met with MOH officials in 2000 to explain the PQI process and its field applications. The team shared how the PQI process had been used in other settings for related technical areas (e.g., the PROQUALI model for improving reproductive health services in Brazil) and demonstrated how the same concepts might be applied at the national level—within the MOH's framework of accreditation—for essential maternal and newborn healthcare services. After a series of discussions, key MOH officials expressed keen interest in implementing the PQI process in healthcare facilities and among healthcare *networks*—covering the range of healthcare provision from health posts to tertiary-level hospitals. Working with the MNH Program, MOH officials began to conceptualize the existence of "quality networks," or *CalíRed*.

In September 2000, the MNH Program arranged for key MOH officials to visit several PROQUALI sites in Brazil. The PROQUALI initiative focused on

establishing and attaining “desired performance” for a number of criteria related to family planning. PROQUALI was well received by community members, healthcare providers, and politicians alike, and results from the initiative demonstrated significant improvements, both in clinical outcome and client satisfaction.

Guatemalan officials and JHPIEGO/MNH Program representatives met with PROQUALI site healthcare providers and government officials, and observed various aspects of quality at the healthcare facilities visited. This insight and understanding of the PQI process convinced the Guatemalan government of the value and urgent need for a similar process in their own country. The MOH agreed to accept technical assistance from the MNH Program to implement *CaliRed* in eight health districts and 154 healthcare facilities in Guatemala.

IMPLEMENTATION OF CALIRED

In 2000, the MNH Program presented the Guatemalan MOH with the World Health Organization’s *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors (MCPC)*. Using the *MCPC* manual, the Vice Minister of Health created a multidisciplinary and intra-ministerial advisory team to revise the national norms, guidelines, and protocols, and to identify gaps between the recommended best practices and current practices.

Following the revision of national guidelines and protocols for essential maternal and newborn care, the MOH and the MNH Program developed a technical instrument to identify the performance required for maternal and newborn services at different types of facilities. Using national norms and international evidence-based standards such as those outlined in the *MCPC* manual, criteria for measuring quality at the network of facilities, including health posts, health centers, and district hospitals, were established. The MOH used the assessment tool in 2002 to conduct the first performance evaluation at a series of healthcare facilities.

Community involvement in developing the assessment tool was necessary and important, especially since the Peace Accords outlined the need for full participation of indigenous people in local and national decision making. Moreover, addressing client preferences was expected to build confidence in the healthcare system and help to ensure increased service use. Community concepts of quality, particularly those that honored indigenous cultural norms and values, were converted to measurable criteria and incorporated into the instrument.



Photo: Oscar Cerdón

To address gaps identified with the PQI tool, a facility in San Pablo arranged to have drinking water available for clients. In addition, the staff created a suggestion box (buzón de sugerencias) for clients' ideas for improvements.

The MNH Program also trained MOH staff in community-based participatory methodologies, so that they could work with communities to detect and analyze

health problems and develop community and family emergency plans. Together with community education geared toward appropriate identification of obstetric, postpartum, newborn, and child warning signs, the emergency plans contribute to timely receipt of care for potentially life-threatening conditions.



A poster shows families how to prepare an emergency plan.

Involving MOH Teams in the PQI Process

MOH involvement was key to the success of *CaliRed*. First, the MNH Program selected and trained MOH personnel to serve on quality teams. These teams learned how to use the

assessment tool to collect baseline measures of quality at the facilities, identify gaps in quality, analyze their causes, and determine the interventions needed to ensure improvements in each facility.

Likewise, to support the necessary interventions, MOH personnel were selected and taught how to form technical teams (doctor/nurse, nurse/auxiliary, or doctor/auxiliary) at each site. These technical teams, in cases where interventions required clinical improvements, provided training that was skill-focused and competency-based. They also introduced new skills through on-the-job training to other providers at their clinical site.

Quality teams monitored change and provided feedback on the results of interventions so that interventions could be modified as needed. To evaluate whether interventions were closing the performance gap, quality teams used the same assessment tool that was used to establish their performance baseline. Information from these evaluations guided further analysis of performance gaps and causes for those gaps, and also served to signal healthcare providers and clients that services were getting closer to the desired level of quality. After 6 to 9 months, MOH teams assessed each facility again to note improvements that would ultimately result in accreditation.

The assessment form was pretested and implemented initially at seven hospitals in three priority health areas (El Quiché, San Marcos, and Sololá). Results would determine whether and how *CaliRed* would expand further.

IMPACT AND RESULTS ACHIEVED

Results from the initial implementation were impressive: facilities' achievement of performance criteria increased from an average of 18 percent of their criteria to an average of 51 percent over the 6 to 9 month period. Quality teams noted improvements in all technical areas (e.g., infection prevention, management of obstetric complications, information systems, and cultural appropriateness).

Healthcare personnel had incorporated improved clinical practices (such as active management of the third stage of labor), cultural practices (such as adapting services to meet the preferences of communities they serve), and support functions (such as upgrading equipment through the help of the MOH).

Subsequent successes at 16 health centers and 30 health posts (where first evaluation scores almost doubled those of the baseline) demonstrated *CaliRed*'s strength to the MOH, healthcare personnel, and community members. Moreover, important changes in evidence-based practices (e.g., restricted use of episiotomy, and active management of third stage of labor) led to other tangible improvements such as reduced patient stay at participating facilities, fewer blood transfusions, and associated cost savings. Such results warranted even stronger national-level commitment.

The ministerial agreement signed in 2001 formalized the *CaliRed* process as a national strategy for improving the quality of maternal and newborn healthcare, facilitating efforts to scale up *CaliRed* and replicate the process in other technical areas. The MNH Program has implemented *CaliRed* in partnership with the MOH in 154 health facilities in 8 health areas. With the ministerial agreement in place, the *CaliRed* process for improving services will expand into 8 additional health areas (222 additional facilities) in 2003, with the support of the MOH and nongovernmental organizations such as Mercy Corps, URC, CARE, the Pan American Health Organization, Project HOPE, and Médicos del Mundo, as well as other USAID projects.

According to the ministerial agreement, accreditation committees must include representatives from public- and private-sector preservice institutions; the national ob/gyn, medical, and nursing associations; the Guatemalan College of Physicians and Surgeons; the Guatemalan Perinatal Medicine Association; the Guatemalan Social Security Institute; the Universidad de San Carlos de Guatemala; and the Guatemalan Medical Women's Association. Such levels of collaboration in support of a common objective are unprecedented in Guatemala.

One of the main constraints facing *CaliRed* is the paucity of resources needed to reduce the gaps identified in the areas of human and material resources. To address these needs, collaborators are working to leverage resources from other NGOs, donors, and municipalities, and have created local alliances in order to include other actors interested in performance and quality improvement for enhanced maternal and newborn survival.

CONCLUSIONS AND FUTURE PLANS

In support of the Guatemalan Peace Accords, the *CaliRed* process has met the Guatemalan government's need for focused efforts to reduce maternal mortality, especially in traditionally underserved rural areas. Through this process, the MOH, health personnel, and communities are working together to improve performance and quality in essential maternal and newborn healthcare. It empowers healthcare providers, community members, and others to identify weaknesses and devise solutions at their facilities, and strengthens the MOH's role in delivering improved

essential maternal and newborn healthcare services. Furthermore, *CaliRed* is realizing aspects of the Social Development Law by encouraging women and communities to actively participate in their own healthcare, ultimately sustaining the delivery of high-quality healthcare services.

In addition to serving as motivation for the various healthcare facilities involved in *CaliRed*, this accreditation model promotes the implementation of reproductive health policy at the local level, thus supporting Guatemala's health reform and decentralization process. Moreover, since communities have participated so actively in defining quality in these settings, they will continue to demand that level of quality and to work on improving it even further.

CaliRed's reach has extended beyond Guatemala. The MNH Program is implementing a similar PQI strategy for essential maternal and newborn healthcare services in Honduras. The Program has worked with hospital staff to adapt and implement quality assessment tools for use in Honduras and has already seen solid improvements in performance.

CASE STUDY #10

PREVENTION AND CONTROL OF MALARIA DURING PREGNANCY IN AFRICA: FROM RESEARCH TO POLICY CHANGE

By Allisyn Moran and Robert D. Newman

Malaria during pregnancy is a significant public health problem, especially in sub-Saharan Africa. Effective strategies have been identified to address this problem, but few countries have been able to translate these strategies into national-level policies and programs. Those countries that have made significant policy changes have engaged in a dynamic process of translating research results into relevant policy. Both locally collected data and data collected in the subregion and region are essential to this process.

MALARIA DURING PREGNANCY: WORLD HEALTH ORGANIZATION RECOMMENDATIONS

Each year, approximately 24 million pregnancies occur among women living in malaria-endemic areas. Malaria during pregnancy can result in maternal anemia, abortion, stillbirth, prematurity, intrauterine growth retardation, and low birthweight. Severe maternal anemia increases the risk for maternal mortality, and anemia caused by malarial infection is estimated to result in approximately 10,000 maternal deaths per year.¹ Low birthweight is one of the greatest risk factors for infant mortality.² As many as 75 percent of the 2.7 million malaria-related deaths each year occur among children in sub-Saharan Africa.³

In 1986, the World Health Organization (WHO) recommended that pregnant women living in malaria-endemic areas should receive chemoprophylaxis with a safe and effective antimalarial drug as part of routine antenatal care (ANC).⁴ Although this recommendation was widely adopted as policy across sub-Saharan Africa, program implementation was often poor or nonexistent, especially in East Africa. In

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2000, the WHO expert committee on malaria recommended that malaria control during pregnancy should emphasize a preventive package of either intermittent preventive treatment (IPT) or chemoprophylaxis.⁵ In 2002, after studies conducted in Malawi and Kenya demonstrated that two treatment doses of sulfadoxine-pyrimethamine (SP) administered as IPT during routine ANC decreased maternal anemia and improved low birthweight,⁶ WHO developed a strategic framework for

the control of malaria during pregnancy in Africa.⁷ The document recommends that pregnant women should receive at least two doses of IPT during the second and third trimesters, as part of routine ANC. WHO no longer recommends chemoprophylaxis due to poor compliance with the weekly regimen and rising resistance to chloroquine.



Photo: Marianne Elias

Women sitting on a clinic bed with an insecticide-treated net in Burkina Faso

Despite the broadening consensus about the effectiveness of IPT in preventing the adverse outcomes of malaria during pregnancy, only five countries in East and Southern Africa (Kenya, Malawi, Tanzania, Uganda, and Zambia) and Nigeria have adopted the WHO recommendations to date. In West and Central Africa, the majority

of countries maintain policies of weekly chloroquine chemoprophylaxis. However, change is slowly occurring, and a coalition has been formed to review the evidence and initiate discussions with policymakers. This case study articulates how research has been used to inform policy dialogue and change in East and Southern Africa as well as West and Central Africa.

TRANSLATING RESEARCH INTO POLICY CHANGE: THE EXPERIENCE OF EAST AND SOUTHERN AFRICA

Changing policy for the prevention and control of malaria during pregnancy is a complex process that has relied on research findings and locally collected data to inform dialogue among key stakeholders. In East and Southern Africa, data have been collected by ministries of health and research organizations to inform policy discussions about issues such as the burden of malaria during pregnancy, the efficacy and safety of antimalarial drugs in pregnant women, the effectiveness of current interventions, and possible alternative strategies to prevent malaria during pregnancy. Some of these data (such as those on the efficacy and burden of disease) need to be generated locally or subregionally, while others (such as those on the safety of antimalarial drugs during pregnancy and possible prevention strategies) may be generated within or outside the region. Each of the five countries that have adopted WHO's recommendations collected some or all of these data to inform policy decisions.

National and subregional dialogue and information sharing are also essential to the policy change process. Once the countries collected data, the data were disseminated and discussed at the national level among key stakeholders, including representatives

of the national malaria control program, researchers, healthcare providers, international organizations, professional organizations, nongovernmental organizations, and different sectors of the healthcare system (such as drug procurement and management divisions of ministries of health). Because interventions for preventing malaria during pregnancy are delivered through ANC services, collaboration between reproductive health divisions and national malaria control programs was a critical part of these discussions.

Malawi

In October 1992, Malawi became the first country to adopt IPT with SP as national policy. In the early 1980s, the unwritten policy for control of malaria during pregnancy was chloroquine chemoprophylaxis.⁸ In 1984, the Ministry of Health of Malawi established a national malaria control committee (NMCC), which was charged with developing an operational research plan to inform the national malaria control strategy. The results of the first round of research studies were presented at meetings with the NMCC in 1989. They demonstrated that chloroquine chemoprophylaxis was ineffective at controlling malaria during pregnancy due to increasing resistance, and that compliance with these regimens was low.⁹ These results suggested that an alternative regimen with a more efficacious drug and simpler dosing would be necessary. The discussions of these results among key stakeholders and within NMCC meetings were critical in creating an environment that was conducive to policy change.

Additional studies further demonstrated the failure of chloroquine to clear malarial infections among pregnant women and children. The Mangochi Malaria Research Project demonstrated that IPT with SP was more effective than either chloroquine chemoprophylaxis or IPT with chloroquine at preventing low birthweight and maternal anemia. These results were presented at an NMCC meeting in November 1992, and the national policy for malaria control during pregnancy was revised. The revised policy included two treatment doses of SP—one dose given at the beginning of the second trimester and one dose given at the beginning of the third trimester as part of routine ANC.¹⁰

Uganda

Like Malawi and other countries in sub-Saharan Africa in the 1980s, Uganda did not have an official policy regarding prevention of malaria during pregnancy. Some healthcare providers prescribed chloroquine chemoprophylaxis to pregnant women, but there was no written policy for prevention of malaria during pregnancy until 1998 (Patrobas Mufubenga, personal communication, February 2003).

Uganda greatly benefited from the research activities and policy dialogue related to malaria during pregnancy in other countries in East and Southern Africa. In Uganda, *in vivo* antimalarial drug efficacy studies were conducted, but data from Malawi and Kenya on the burden of malaria during pregnancy and on the effectiveness of chemoprophylaxis versus IPT were used to inform policy discussions. The Minister of Health was very supportive of adopting and implementing an effective policy to

address malaria during pregnancy (Patrobas Mufubenga, personal communication, February 2003). This national political will and support for policy change was strengthened by support from international organizations and donors. Thus, the combination of strong political will, rising resistance to chloroquine, data on effectiveness of IPT with SP, policy change in the region, and pressure from international organizations led to the policy change in 1998. Uganda adopted a policy of two doses of IPT with an effective antimalarial (SP), with one dose in the second trimester and one in the third trimester administered as part of ANC.

POLICY CHANGE IN EAST AND SOUTHERN AFRICA: SUMMARY AND NEXT STEPS

The policy change process in Uganda and Malawi relied on data to inform discussions among stakeholders and ensuing changes in policy. Although locally collected data are essential, the experience in Uganda demonstrates that data collected in the subregion can be sufficient to inform the policy change process. In both Uganda and Malawi, national-level support from ministries of health and national malaria control programs was essential to ensuring that prevention of malaria during pregnancy remained a priority. Collaboration among national malaria control programs, reproductive health divisions, drug procurement and distribution divisions, pharmaceutical companies, researchers, policymakers, international organizations, and healthcare professionals in defining and discussing research questions and results is critical to the success of translating research into policy change.

POLICY CHANGE PROCESS IN WEST AND CENTRAL AFRICA

In West and Central Africa, the majority of countries have a policy of chemoprophylaxis with chloroquine to prevent malaria during pregnancy. Building on the lessons learned in East and Southern Africa, a coalition of organizations working in reproductive health and malaria research worked with ministries of health to initiate a process of policy dialogue in West and Central Africa.

First, local data on malaria during pregnancy were collected from three countries—Mali, Burkina Faso, and Benin—between 1998 and 2001. In 1998, the Centers for Disease Control and Prevention (CDC) began working with the Mali Ministry of Health and the Mali Malaria Research and Training Center at the University of Mali to conduct a rapid assessment of the burden of malaria during pregnancy and a randomized controlled trial to examine the efficacy and safety of three different regimens to prevent malaria during pregnancy—IPT with chloroquine, IPT with SP, and weekly chloroquine chemoprophylaxis.

In 2000, CDC, the Centre National de Recherche et Formation sur le Paludisme (part of the Ministry of Health of Burkina Faso), and JHPIEGO, through the Maternal and Neonatal Health (MNH) Program, conducted a rapid assessment of the burden of malaria during pregnancy in Burkina Faso. The Benin Ministry of Health, CDC, and Africare conducted a similar collaborative assessment in Benin. Since few data are available on the burden of malaria during pregnancy in West and Central Africa, these rapid assessments were essential in supplying locally relevant

data. Each of these studies represented close collaboration between international organizations, ministries of health (national malaria control programs and reproductive health divisions), and local malaria researchers.

Once the data were collected, the results were disseminated at the national level by ministries of health, national malaria control programs, and local researchers. The results of the rapid assessments in Benin and Burkina Faso, as well as the randomized controlled trial in Mali, were discussed at national meetings that included representatives from reproductive health and national malaria control programs, researchers, donors, and bilateral organizations, as well as healthcare providers and other nongovernmental organizations working in malaria during pregnancy. These meetings resulted in rich discussions on the burden of malaria during pregnancy and the effectiveness of current policies and programs, and provided an opportunity for key stakeholders to share knowledge and initiate dialogue about current policies. However, there was reluctance to move to national-level policy change, due to concerns about the safety of SP during pregnancy and the belief that current chloroquine chemoprophylaxis programs may still be effective (Todd Mercer and Kassoum Kayentao, personal communication, November 2002).

In March 2002, the MNH Program and CDC organized a workshop with representatives from seven West and Central African countries to facilitate subregional dialogue about malaria prevention and control during pregnancy. Sixty-five participants attended from Benin, Burkina Faso, Cameroon, Cote d'Ivoire, Mali, Senegal, and Togo. Representatives from each country's national malaria control program and division of reproductive health, and from the local UNICEF and WHO offices, attended. Researchers who had conducted the studies in Benin, Burkina Faso, and Mali also participated. International representation included the WHO/Africa Regional Office, WHO/Headquarters, CDC, UNICEF/New York, the MNH Program, and USAID.

The 3-day workshop included presentations on the current policies for prevention of malaria during pregnancy in each country, the results from the studies in Benin, Burkina Faso, and Mali, the current WHO guidelines, and the experiences of implementing IPT with SP in East and Southern Africa. In Burkina Faso, the rapid assessment demonstrated that peripheral and placental malaria remain common despite the widespread use of chloroquine chemoprophylaxis by pregnant women. In addition, peripheral malaria infection was strongly associated with anemia and moderate-to-severe anemia among women in ANC, and placental malaria was strongly associated with low birthweight and premature delivery.¹¹ In Benin, the rates of placental parasitemia among pregnant women were lower than expected. However, malaria was associated with moderate-to-severe anemia and low birthweight. Correct use of chloroquine chemoprophylaxis was reported by less than half of women (Robert Newman, personal communication). The randomized controlled trial in Mali demonstrated that rates of placental parasitemia, maternal anemia, and low birthweight were lower in women receiving IPT with SP when compared with IPT with chloroquine or chloroquine chemoprophylaxis.¹²

After the presentations, the participants were divided into country teams to develop action plans for next steps on how to prevent and control malaria during pregnancy in their respective countries. On the last day of the workshop, country teams presented their action plans. A total of six countries committed to conducting pilot interventions of IPT with SP (Benin, Burkina Faso, Cote d'Ivoire, Mali, Senegal, and Togo), and three of these countries (Mali, Senegal, and Togo) decided to initiate changing their policy to IPT with SP. In addition, the participants discussed the possibility of creating a network for control of malaria during pregnancy in West and Central Africa to facilitate communication, coordination, sharing of materials, and advocacy among countries.

POLICY DIALOGUE IN WEST AND CENTRAL AFRICA: SUMMARY AND NEXT STEPS

Like the process of policy change undertaken in East and Southern Africa, the process of initiating policy dialogue related to prevention of malaria during pregnancy in West and Central Africa relied on discussions of research findings to inform policy change. The experience in West and Central Africa also demonstrated that locally collected data on the burden of disease and alternative strategies are important, but subregional and regional data on the efficacy and safety of antimalarials in pregnant women and alternative strategies can also be used to influence policy dialogue. In addition, the process in West and Central Africa has shown that subregional discussion and dissemination of information among key stakeholders can serve as an impetus for policy change. The results disseminated at the national level in Burkina Faso, Benin, and Mali created a rich discussion and debate, but overall, policymakers were initially skeptical toward policy change. At the subregional workshop, stakeholders had the opportunity to discuss the current situation and research findings across the subregion. This data-sharing activity and ensuing discussion led to willingness to try IPT with SP as a pilot intervention, thus moving the process forward more quickly.

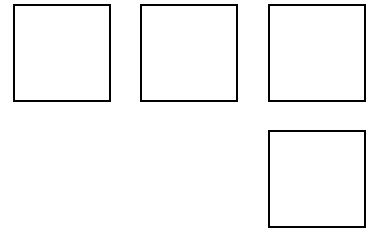
CONCLUSION

The process of using research to inform policy is dynamic and complex, and both locally collected data and data collected in the subregion and region are needed. The lessons learned from the process in East and Southern Africa and in West and Central Africa demonstrate that political will at the national level is crucial in translating research findings into policy change. In addition, collaboration among all stakeholders, including researchers, policymakers, healthcare professionals, drug management and supply systems, national malaria control programs, malaria researchers, and reproductive health departments, is essential. Collaboration with reproductive health departments is especially crucial, because malaria during pregnancy interventions are implemented through ANC. Subregional and regional sharing of research findings and lessons learned can facilitate the policy change process. Once policy change has occurred, subregional as well as regional dialogue and collaboration around malaria during pregnancy is important—to share tools, strategies, and lessons learned.

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THE POWER OF PARTNERSHIPS:

Moving the
Agenda Forward

SHAPING
POLICY
for Maternal and
Newborn Health

CASE STUDY #11

MEXICO'S NATIONAL SAFE MOTHERHOOD COMMITTEE: BUILDING COMMITMENT AND SUSTAINING LINKAGES

By María del Carmen Elu and Martha Murdock

The Mexico National Safe Motherhood Committee (NSMC) is an innovative example of how common ground can be used to forge nontraditional but effective partnerships, and how these partnerships can develop sustainable initiatives for women's reproductive health and rights at the national and local levels.

In 1992, maternal mortality was an urgent problem in Mexico. Although the government recognized the issue and wanted to improve maternal health, bureaucracy and frequent changes in political leadership hampered action on the issue. The Ministry of Health (MOH), which provided the great majority of health services in Mexico, rarely consulted or collaborated with local nongovernmental organizations (NGOs) and women's groups, at either the national or the state level.

The first National Safe Motherhood Conference in Mexico, held in 1993, determined that, although progress toward reducing maternal mortality was stalled, enthusiasm, infrastructure, and resources could potentially be mobilized to try a new, more effective approach. Safe motherhood offered a common ground that government, grassroots women's groups, and nontraditional partners all shared, and the conference itself provided the opportunity for these partners to work together for the first time. The conference forged multisectoral linkages that brought together public, private, international, national, and local partners. These partners initiated dialogue about specific priorities for action at the conference, and began shaping their working relationships. Once trust was established, a committee was formed to build on its members' diverse strengths and to create a non-hierarchical alliance to support advocacy and action from the ground up, as well as from the policy level

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down. This committee is now an innovative and successful mechanism for implementing national policies in local communities and for bringing worthy local initiatives to the national policy level.

The National Safe Motherhood Committee in Mexico is proof that safe motherhood can open doors for broader reproductive health issues, including women's rights, unsafe abortion, and violence against women. Most importantly, it has achieved clear, and even unexpected, successes in more than 10 years of operation.

PHILOSOPHY, STRUCTURE, AND GOALS

Originally launched as an interagency group to promote followup to the 1993 national conference, the NSMC has become an active, 30-member alliance that works closely with decision makers and collaborating agencies. It has spawned state-level committees in nine states, which instigate local initiatives and implement national ones. Many of the activities are now taking place at the state level.

- **Operation:** Since the committee's inception, Family Care International (FCI) has supported and helped raise funds for a technical secretariat, which has provided the committee with on-site, autonomous, and uninterrupted leadership. The entire committee meets in plenary every 2 months, and subgroups carry out interim work. It receives funding and in-kind contributions from national and state members, and support from major foundations and United Nations agencies.

Table 3. Members of the National Safe Motherhood Committee, Mexico

GOVERNMENTAL ORGANIZATIONS		STATE SAFE MOTHERHOOD COMMITTEES	
Cámara de Diputados		Chiapas	Querétaro
Coordinación de Salud Reproductiva y Materno Infantil, IMSS		Guerrero	San Luis Potosí
Coordinación de Salud Reproductiva, ISSSTE		Morelos	Tlaxcala
Dirección General de Equidad de Género en Salud, SSA		Oaxaca	Veracruz
Dirección General de Salud Reproductiva, SSA		Puebla	
Instituto Nacional de Perinatología			
Secretaría de Salud del D.F.			
Sistema Nacional para el Desarrollo Integral de la Familia			
NONGOVERNMENTAL ORGANIZATIONS		INTERNATIONAL ORGANIZATIONS	
CIDHAL-Centro para Mujeres		Family Care International	The Population Council
Comunicación e Información de la Mujer (CIMAC)		UNICEF	Salud Integral para la Mujer
Fundación Mexicana para la Planeación Familiar (MEXFAM)		UNFPA	(SIPAM)
Instituto Mexicano de Estudios Sociales A.C. (IMES)		MacArthur Foundation	Ticime Grupo de Partería
K'inal Antzetik (Coordinadora Nacional de Mujeres Indígenas)		Pan American Health	
Programa Universitario de Estudios de Género, UNAM		Organization	

- **Goals:** The NSMC's work plan and objectives are organized around six priorities: raising awareness; improving policy and parliamentary support; promoting state-level action; advancing research; encouraging community education and participation; and strengthening health service delivery.
- **Keys to success:** A key element of the committee's success has been the strong and consistent leadership and vision provided by the committee's secretariat, who brought to the table technical expertise, political skills, and a profound commitment to the issues. In addition, the committee has been successful in fostering cooperation and mutual respect between public-sector and NGO partners involved in the national safe motherhood initiative. Its decision making is democratic and horizontal, and its activities are focused and have clear objectives. All partners benefit from the alliance. Members seek partnerships with nonmembers to capitalize on others' expertise and build support and sustainability. Flexibility on the part of committee members and donors is essential, because success or failure often depends on an immediate response to sudden (often local) opportunities. These opportunities include unexpected contributions of financial or human resources by local partners, and changes in the policy climate resulting from state or national elections/appointments (such as the appointment of a new, progressive Minister of Health).

THE ROLE OF THE COMMITTEE IN NATIONAL POLICY FORMATION

The NSMC is deeply committed to national policy reform and makes it a priority to contact newly elected public officials in the health, education, and gender sectors immediately to raise their awareness about reproductive health issues and needs. Members hold regular meetings with top policymakers to promote strategies and reform at the national and state levels. In 1995, the committee was invited to join the National Inter-institutional Group on Reproductive Health, a group of public health institutions and six NGOs that was formed to guide the development of reproductive health policies and monitor the national program. The committee is also a member of the Technical Council of the National Program on Women and Health (PROMSA), one of the key governmental policymaking bodies on women's reproductive health in Mexico.

At the national level, the NSMC has played a key role in reviewing and shaping national policy relating to women's health in Mexico. It is consulted regularly by government, is seen as an authority/expert on maternal health issues, and is frequently invited to participate in the highest-level policy and programmatic forums on women's reproductive health.

- **Policy reform:** The committee reviews and analyzes national norms and legislation related to women's reproductive health and rights, and makes recommendations to the national legislature. In 1994, within a year of its formation, the committee demonstrated its expertise by offering language-specific recommendations for the National Family Planning Norms. The committee drafted comprehensive recommendations on the draft norms, and followed up with meetings with key policymakers to promote the recommendations. As a result of these efforts,

70 percent of the recommendations were accepted. In a similar fashion, the committee helped draft the following documents:

- Maternal Infant Care norms (1996)
- Norms for Cervical Cancer and Pregnancy Care (1999)
- Official Protocol for Care During Pregnancy, Delivery, and the Postpartum Period (2002)

The committee is also working to ensure that national policies are responsive to the sexual and reproductive health needs of migrant women, and to protect the sexual rights of incarcerated women. It will advocate for the revised draft Family Planning Norms, which include emergency contraception, and are scheduled for release in late 2003 for public comment and review.

- **National policy and program design:** In early 2002, the administration of President Vicente Fox created *Arranque Parejo en la Vida*, an important federal program that offers universal health coverage for pregnant women and for children up to age 2. The NSMC was invited to join the executive committee for this program, and advocated successfully for the reduction of maternal mortality by 35 percent as the program's primary goal. As part of its collaboration, the committee's technical secretariat is helping to draft a charter on the rights of pregnant women, which will be published and distributed nationally to women through clinics, women's groups, and other organizations, and also through the state-level safe motherhood committees. The committee's technical secretariat also helped inaugurate the *Arranque Parejo* program in the states of Morelos and Aguascalientes during public ceremonies that received extensive coverage in state media channels.

ACTION AT THE STATE LEVEL

The creation of state-level safe motherhood committees supported by, and now also supporting, the national committee has been a unique and effective way to nationalize grassroots activities and provide a direct link between public policy and local implementation. In 2003, nine states have functioning committees (Oaxaca, Querétaro, Veracruz, San Luis Potosí, Morelos, Chiapas, Puebla, Tlaxcala, and Guerrero).

Figure 1: Map of Mexico



Note: In 2003, nine states in Mexico have functioning safe motherhood committees.

State committees were originally established and consolidated with the help of the national committee, which provided technical and financial support for local conferences, assistance with conference declarations and followup frameworks, and operational guidelines for the new state-level partnerships. The state-level committees function independently, and work closely with each other. Now, close, democratic relationships exist between the national and state committees, with state committee representatives serving as members of the national committee and state committees undertaking their own initiatives with national committee support. Since 1998, the Mexican MOH has funded the participation of state-level ministries in the plenary national committee meetings.

Many of the national committee's activities are currently taking place at the state level. The state committees are helping to pilot-test programs and developing their own initiatives, which may be brought to national scale or used to shape national policy. State activities have had a significant influence on a variety of national issues, including violence against women, reproductive rights, adolescents, and migrant women's access to services.

As an example, in 1999 the national committee and five state committees worked together to design and pilot-test the Health Post Project, an effort to provide free outreach and education to pregnant women on self-care during pregnancy. The outreach project, which was conducted in public markets and fairgrounds, was so successful that the Mexican MOH replicated this initiative nationally in 2001, with no external donor funding.

SCALING UP: BUILDING NATIONAL PROGRAMS FROM LOCAL INITIATIVES

The National Safe Motherhood Committee has developed and tested innovative pilot projects at the state level, which can then be brought to national scale. One example of a national project that began at the grassroots level is the Violence Prevention Project.

Since 1998, the national committee has been working to prevent domestic violence, focusing primarily on reducing violence during pregnancy. In 1997, Mexico passed a law criminalizing domestic violence, and the national and state committees saw an opportunity to take immediate action to implement the law. The national committee launched radio programs to raise awareness and developed a resource guide for health workers on how to identify, counsel, and refer pregnant victims of abuse. The guide was created in collaboration with national and state-level agencies and tested by three state committees. It includes a background manual on the issue, a policy framework and guidance on the role of the healthcare provider, a training manual for health workers, and a contact list of medical, legal, and social services.

The state safe motherhood committees have been involved in every stage of this project, including providing support in drafting and pretesting the training manual, soliciting support for the guide from local policymakers and health authorities, leading public launches of the guide with key state-level partners, and coordinating training programs on the guide with MOH partners.

Training for healthcare workers has become the centerpiece of this project. The national committee received strong support from the MOH, which revised its Health Norms to include standards of care for treating victims of violence (published in 2000). Prevention of violence against pregnant women is now a specific objective of the Women's Health and the Reproductive Health and Family Planning programs. Since January 2002, state committees in Chiapas, Morelos, Oaxaca, Querétaro, San Luis Potosí, and Tlaxcala have held training workshops (using the manual) for healthcare workers on domestic abuse, and almost every state committee has organized a conference on the problem.

The manual has also become a primary tool for the MOH. Since 2000, more than 700 healthcare workers throughout the country have attended workshops and training sessions on gender violence and how to use the manual. In 2003, the National Program for Women and Health reprinted the training manual, and pledged support for three teams of mobile trainers in different regions to lead training sessions using this tool. In Morelos and San Luis Potosí, state committees are drafting a guide for providing comprehensive and high-quality care and counseling for all victims of sexual assault, including information on safe abortion services, where they are legal. This corollary project is becoming a collaborative venture, with interest and support from many country partners, including the United Nations Population Fund.

AWARENESS RAISING AND OUTREACH

One example of the synergy between policy and action is Mexico's involvement in the 1994 International Conference on Population and Development (ICPD). Committee members helped the NGO coalition from Mexico formulate its platform for the ICPD. Then, following the ICPD recommendation to ensure gender sensitivity in health services, the national committee held workshops around the country to improve awareness and provide training in gender issues for 1,000 participants. These workshops resulted in the appointment of a full-time specialist to help redesign national reproductive health and family planning programs and policies to reflect gender equities in MOH programs. The NSMC will also be closely involved in NGO preparatory activities for ICPD+10, and is working with the national governmental delegation in an effort to help strengthen the delegation's support for sustaining the Cairo commitments.

The national and state committees also work together to raise awareness about women's reproductive health needs and rights at the state and the grassroots level. In early 2003 the committee produced a Safe Motherhood Media Guide to help local partners work more effectively with the media. As a result of the committee's efforts, October has been declared National Reproductive Health Month and a national postage stamp on safe motherhood was created and circulated. In addition, the committee sponsors a national contest (now in its third year) to recognize innovative and exceptional efforts to prevent maternal deaths. A prize rewarding the greatest contribution by a non-medical person has created much goodwill and visibility for the idea that everyone and anyone can and should help make motherhood safer.

CONCLUSION

In July 2003, the National Safe Motherhood Committee celebrated its tenth anniversary with a national 3-day conference on safe motherhood that provided an opportunity to highlight lessons learned through the initiative and define priorities for future action. As a result of all it has accomplished in the last 10 years, the NSMC is now officially recognized as one of the primary experts on maternal mortality in Mexico, and has been an influential voice for action on a broad range of issues surrounding women's reproductive and sexual health and rights. It has been visible and influential during changes in the national administration over the last 10 years, and has given birth to an effective network of innovative state committees.

The NSMC's holistic and democratic approach, which capitalizes on the diverse strengths of its partners, has contributed immeasurably to the committee's sustainability. The technical secretariat has provided unwavering support and limited financial support to fledgling networks, helping them build technical and institutional capacity within the broader network. The committee's flexibility and respect for diversity have been among the keys to its success. But perhaps the most important reasons for the NSMC's success are its dynamic leadership and its ability to respond to both national and local needs, which allows for a smooth and equal interchange between the national and the grassroots levels.

CASE STUDY #12

THE REGIONAL TASK FORCE ON MATERNAL MORTALITY REDUCTION: DEVELOPING CONSENSUS ON SAFE MOTHERHOOD PRIORITIES IN LATIN AMERICA AND THE CARIBBEAN

By Alma Virginia Camacho, in consultation with the Regional Task Force on Maternal Mortality Reduction

Although reducing maternal mortality is a regional priority in Latin America and the Caribbean (LAC), implementing country-level strategies for reducing maternal mortality presents unique challenges. Safe motherhood–friendly policies are largely in place across the region, but national political commitments need to be strengthened and focused on effective strategies and interventions. A great divide has developed between maternal health services for the rich and those for the poor, and for urban versus rural populations; the needs of certain groups, such as indigenous and adolescent women, are seriously neglected.

In 1998, an inter-ministerial regional meeting was held in Peru to assess progress toward the goals of the World Summit for Children. The assessment found that little progress had been made in maternal mortality reduction. Based on these findings, a regional task force—the Regional Task Force on Maternal Mortality Reduction—was created to monitor progress in priority countries and to address some of the region-specific challenges to maternal mortality reduction by improving interagency coordination and collaboration, and by providing support and focus to country-based partners. Specifically, the task force was designed to:

- Provide momentum and promote effective implementation of progressive safe motherhood policies and programs that are in place throughout the region;

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- Share information between agencies on lessons learned and proven best practices, and promote the expansion or adaptation of successful models within the region;
- Leverage dwindling donor resources (by working collaboratively and avoiding duplication); and
- Monitor trends in maternal mortality reduction and mobilize technical and financial resources.

This case study documents the task force's development and its effort to forge a regional consensus on safe motherhood priorities.

MISSION, GOALS, AND ORGANIZATION

The Regional Task Force on Maternal Mortality Reduction was initiated with the technical support of the Pan American Health Organization's (PAHO's) Maternal Mortality Reduction Initiative team, which also serves as the group's technical secretariat. While its primary focus is on supporting country efforts, it also facilitates interagency communication at both the regional and global levels (the latter through linkages with the global Safe Motherhood Inter-Agency Group). The task force's agenda and operating principles are based on globally accepted agreements and experience, including the International Conference on Population and Development commitments; PAHO's Regional Plan for the Reduction of Maternal Mortality (in which all Ministers of Health from LAC endorsed maternal mortality reduction as a priority in 2002); and the lessons learned in the first 10 years of the Safe Motherhood Initiative (as set out in its action messages).

Goals of the Regional Task Force on Maternal Mortality Reduction:

- Develop a regional framework and support the implementation of national maternal mortality reduction plans
- Identify common themes and gaps in country programs
- Promote policy dialogue
- Promote evidence-based interventions
- Facilitate the functions of country-level task forces and partners

To date, the task force has established itself as an entity; set its mission, goals, and work plan; identified five priority countries for national action; and helped develop and support the activities of three national task forces (with more to come).

Membership

Founding members of the task force include three United Nations agencies (UNFPA, UNICEF, and PAHO), one bilateral agency (USAID), two development banks (the World Bank and the Inter-American Development Bank), and two international

nongovernmental organizations (The Population Council and Family Care International). All are key players with extensive regional and national programs, and established links with country partners. Each member agency is committed to maternal mortality reduction and to strengthening its activities and securing safe motherhood as a high priority in the region.

Since the task force was conceived to play a leadership role in the region, it is crucial that each member agency is highly committed, and that the heads of each group endorse task force activities and products. Therefore, membership is limited, and every effort is made to ensure continuity of representation. Each agency has assigned one or two key persons from its headquarters, with expertise and involvement in that agency's safe motherhood efforts, as its representative and regional point person, responsible for sharing information on the task force's progress and outcomes with both headquarters staff and country teams.

Organization

The task force meets three times a year, usually in Washington; ad hoc subcommittees meet periodically as required. The full-day plenary meetings provide an opportunity to review progress on the annual work plan, as well as the progress and challenges faced by country-level task forces. The secretariat is responsible for convening and hosting task force meetings, supporting the implementation of the work plan and the activities of the subcommittees, and providing technical support to country-level task forces, as requested.

Priority Countries

In 2002, Bolivia, Guatemala, Peru, Haiti, and Nicaragua were identified as priority countries, based on the severity of maternal mortality in each country, existing political momentum, agency priorities, and the stage of national policy development. Bolivia, Haiti, and Nicaragua have established national task forces made up of incountry representatives from the regional task force agency members (and in the case of Bolivia, other agencies that are involved in maternal mortality reduction efforts).

SETTING REGIONAL STRATEGIES AND PRIORITIES: DEVELOPING A CONSENSUS DOCUMENT

One of the task force's first priorities was to identify regional needs and tailor strategies to address them. Members began by reviewing the global UNFPA/UNICEF/WHO joint statement on maternal mortality reduction that was published in 1999 and drafting a similar statement for discussion with local and national stakeholders. PAHO developed the outline, and task force members drafted sections according to their particular areas of expertise. The sections were then compiled, edited, and reviewed by the secretariat and resubmitted for member feedback.

The resultant draft was carefully reviewed by country teams at two subregional meetings—the first in Managua, Nicaragua (in April 2001) for Central American and Caribbean partners; and the second in Santa Cruz, Bolivia (November 2001) for Andean countries and southern tip of South America. Each meeting attracted some 100 representatives from a broad range of partners, including country teams from task force agencies, health sector partners, policymakers, researchers, women's group representatives, and indigenous leaders. In Bolivia, the National Safe Motherhood Committee even coordinated a preparatory round of district-level workshops and

one national workshop with representatives from the public health sector and nongovernmental organizations to review the draft document, with funds from one of the national committee's members, UNFPA.

Stakeholder input highlighted issues specific to the region (such as the role of traditional midwives, especially in indigenous communities), helping to create a sense of ownership that would stimulate followup at the local level. The review process was inclusive and participatory and required extensive time and effort in order to build consensus on the strategy. Feedback resulted in greater focus on evidence-based health interventions, a rights-based approach to health and gender, and a consistent effort to be inclusive (across sectors, and among a range of languages and diverse regions). Ministry of Health participants reported that the two meetings also helped to mobilize country-level interest in maternal mortality reduction efforts and to prepare national governments for the document.

The resulting consensus document, *Inter-Agency Regional Consensus Statement on Maternal Mortality Reduction*, was finalized in May 2003 and now provides a catalyst for programming and increased political commitment.

Launch and Followup Activities

In the fall of 2003, the consensus document will be formally launched in Washington by the member agencies of the task force. The launch will serve as a public forum for the agencies to express their support for the document. This event will also be an excellent opportunity to increase national and global media coverage on the importance of maternal mortality reduction.

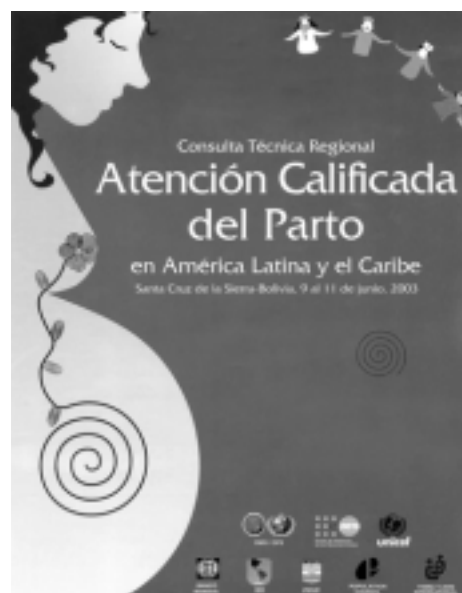
Following the formal launch, the task force will encourage country-level launches, coordinated by the national task forces and agency partners in the other priority countries. Launching the joint statement at the country level will provide a stimulus and framework for national policymakers to revise their maternal mortality reduction strategies according to national needs and priorities and to reflect the consensus document. Following the launches, the regional task force will work with teams in each of these countries to articulate and advance local safe motherhood action plans (through regional or country level technical meetings, resource allocation, and so on) to implement the consensus document.

Moving from Consensus to Action: Prioritizing Skilled Care

On 9–11 June 2003 in Santa Cruz, Bolivia, the regional task force convened a 3-day technical consultation on skilled attendance at birth, which is one of the major priorities outlined in the consensus document. The agenda for the Technical Consultation on Skilled Attendance at Birth in Latin America and the Caribbean included challenges of data collection and monitoring; quality of care; cultural access and building an enabling environment for skilled care at the community level; strengthening the role of medical and nonmedical professional care providers; and promoting women's involvement. PAHO and Family Care International, in conjunction with the Collaborative Partnership on Nursing and Midwifery Group,

were primarily responsible for planning the conference on behalf of the task force, but all task force members were involved and actively participated. The 120 conference participants included specialists from schools of medicine, nursing, public health, and midwifery; members of key professional associations (such as the International Confederation of Midwives and the Latin American Federation of Obstetricians and Gynecologists); and task force members and other partners. Panels and workgroup discussions among the 11 country teams stimulated dialogue between medical and nonmedical professionals on strategies for increasing access to skilled care both at the regional and country levels.

During the intensive technical consultation, each country-level team developed concrete recommendations for implementing skilled care at the country level. In the year ahead, regional and country-level task force members will work to stimulate followup action on these priorities. A report on the technical consultation is being produced in Spanish and will be disseminated in the fall of 2003.



Cover: Regional Task Force on Maternal Mortality Reduction

VALUE ADDED BY INTERAGENCY COLLABORATION

Poster for the Technical Consultation on Skilled Attendance at Birth, 9–11 June 2003

The Regional Task Force on Maternal Mortality Reduction has helped to build commitment to safe motherhood within its member agencies and to increase intra-agency support for best practices in maternal healthcare. Members report that their involvement in the task force has helped ensure that maternal mortality reduction efforts remain a priority within their regional programs (in the face of competing needs) and that funds are allocated to this priority. Examples from select member agencies include the following:

- Maternal mortality reduction is a key Millennium Development Goal for each of the international task force member agencies, and each agency is now working to scale up its commitment. The World Bank and the Inter-American Development Bank provide resources for maternal mortality reduction through country-level health sector loans.
- In September 2002, the Pan American Sanitary Conference, which is attended by all Ministers of Health from the region, adopted a resolution on maternal mortality reduction that prioritized proven effective interventions.
- All members report that the group has spurred interagency coordination for safe motherhood at the country level (especially around technical meetings, and with inclusion of international nongovernmental organizations) and has helped them mobilize funds for national task force partners to attend regional events. (Many countries funded their own participation at subregional meetings in 2001/2002.)

The task force is also providing opportunities for collaboration between members in other areas. For example, PAHO is developing a series of case studies on successful safe motherhood interventions in LAC along with local research partners in Costa Rica and Chile. UNFPA is working closely with PAHO on these case studies, and other members discussed the possibility of collaboration on additional case studies.

The national task forces that have been developed with the aid of the regional task force are duplicating this collaborative model: improving interagency and governmental dialogue and coordination, and sharing tools and lessons learned.

STRENGTHS AND LIMITATIONS OF THE TASK FORCE

Some of the factors influencing the task force's success include the following:

- **Dynamic leadership:** Under the continuous coordination of PAHO as the technical secretariat, the task force has sustained its momentum and focus.
- **Limited size:** The task force has remained agile and flexible due to its small core team of member agencies. At the same time, each member can call on an extensive network to respond to requests from country-level task forces and national governments.
- **Continuity of members:** To the extent possible, members have worked to ensure the continuous participation of one person on the task force, which has helped sustain commitment and strengthened working relationships.
- **Inter-sectoral focus:** Diversity in member agencies has played a key role in promoting a rights-based approach, and in considering the broad range of factors that affect maternal health.
- **Participatory process:** The task force works to build consensus. Active e-mail exchanges between meetings permit members to share priorities and concerns, and to move the work plan forward. The group's participatory process has helped foster the creation of new alliances among and between national and regional stakeholders (through the national task forces).

Some of the limitations and challenges the task force faces are:

- **Need for consensus building:** Reflecting and incorporating the broader perspectives of the various members on strategies for reducing maternal mortality is worthwhile and enriching, but requires significant discussion and negotiation.
- **Lengthy approval processes:** The need to seek the highest level of endorsement from each member can limit the task force's agility, flexibility, and timeliness. Members must have recognized decision-making authority within their organizations, access for obtaining high-level approval as necessary, and sustained commitment despite competing priorities.

- **Linking with country partners:** To turn its advocacy and leadership into local action, the regional task force must have strong incountry counterparts and support from local governments.
- **Limited financial and human resources:** The task force is a volunteer body with no paid staff; it relies on the commitment and contributions of members to carry out all its activities.

CONCLUSION

International and national partners have been collaborating for more than a decade to reduce maternal mortality and morbidity. In that time, significant progress has been made and lessons have been learned on a global level. There is also a growing body of international agreements that advance and broaden the priorities for reducing maternal mortality. Although the Regional Task Force on Maternal Mortality Reduction is one of the first regional inter-sectoral bodies created to specifically address maternal mortality, its work plan is framed within each member agency's efforts to advance and implement existing international agreements relating to women's health and rights, such as the International Conference on Population and Development Programme of Action and the World Summit for Children, and to promote forward-looking goals and activities, such as the Millennium Development Goals and upcoming activities to mark the tenth anniversary of the International Conference on Population and Development. Reflecting the task force's growing visibility and achievements, the global Partnership for Safe Motherhood and Newborn Health, which will be formally launched in late 2003, has invited the task force to serve as a member of its steering committee.

The work of the regional task force is timely. In LAC, as in much of the rest of the world, there is growing recognition that women should not die unnecessarily during childbirth. Safe motherhood therefore serves as a key point of accord, and has proven to be a successful entry point for broader women's health issues. Consensus and commitment will be critical to ensure that action is taken to save the lives of more women.

The Maternal and Neonatal Health Program

The Maternal and Neonatal Health (MNH) Program is committed to saving mothers' and newborns' lives by increasing the timely use of key maternal and neonatal health and nutrition practices. The MNH Program is jointly implemented by JHPIEGO, the Johns Hopkins Center for Communication Programs, the Centre for Development and Population Activities, and the Program for Appropriate Technology in Health.

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Saving Newborn Lives/Save the Children

Saving Newborn Lives, a 15-year Save the Children initiative to improve the health and survival of newborns in the developing world, was launched with a gift from the Bill & Melinda Gates Foundation.

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Family Care International

Family Care International is dedicated to improving women's sexual and reproductive health and rights in developing countries, with a special emphasis on making pregnancy and childbirth safer.

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This collection of case studies was developed by JHPIEGO/Maternal and Neonatal Health Program, Saving Newborn Lives/Save the Children, and Family Care International to demonstrate different approaches to influencing national policies on maternal and newborn health. The case studies highlight the strategies and processes involved in securing national policy commitments to improve healthcare for mothers and newborns. Each one presents a strategy that has been used to achieve or influence policy change in a country or region, details of the implementation process, and the changes that have been made in maternal and newborn health and healthcare as a result. Together the case studies show how civil society and nongovernmental organizations can contribute to positive change for safe motherhood and newborn health.

About SHAPING POLICY for Maternal and Newborn Health

Topics covered include:

- Expanding the public health infrastructure to promote breastfeeding
- Using international guidelines to update national policies and protocols
- Mobilizing demand for immunization against tetanus
- Advocating for local resources for maternal health
- Using research to influence national policies on prevention and treatment of malaria during pregnancy
- Developing a national neonatal health strategy
- Training and authorizing mid-level providers to manage maternal complications
- Implementing a nationwide performance and quality improvement initiative
- Building national and regional consensus on safe motherhood priorities